MAXIMUS Federal Services

Case Number:	CM14-0147100		
Date Assigned:	09/15/2014	Date of Injury:	07/01/1992
Decision Date:	10/23/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/10/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The claimant was injured on 07/01/92. The nature of her injury is unclear but she has chronic pain involving her neck and low back and also reported that she developed RSD. Valium, Soma, Oxycodone, and Zanaflex are under review. She is status post cervical fusion and discectomy, CRPS stellate blocks and cervical and lumbar epidurals. She was evaluated on 03/31/14. She reportedly had a significant head injury in 1997 when a 20 pound box hit her and she was in rehabilitation for 6 months. She had a previous cervical fusion in the past. She reported a repetitive lifting injury. She complained of pain all around the bilateral low back with some pain in the right side of her neck and shoulder and both legs went numb. Her activities made her worse. She has to self-cath periodically. She was receiving home health care. Physical examination revealed tenderness about the neck with diminished range of motion of the lumbar spine. She was unsteady on her feet. Straight leg raise was positive in the left lower extremity at 40 and reproduced her pain down her leg. On 04/14/14, her medications included Oxycodone, Tizanidine, Diazepam, Lyrica, and Soma. She needed some refills of Oxycodone, Tizanidine, Promethazine, and Diazepam but not refills of Lyrica or Soma. There was no change and she was given refills. On 05/13/14, she stated that her pain was 8/10 and with medications, particularly oxycodone, it went down to 6/10. She was doing PT. Valium and muscle relaxants were the only thing that helped. There was no aberrant drug-seeking behavior. She was using a walker. She was not examined. She stated that promethazine helped with the nausea. Otherwise her use of medications was about the same. On 06/12/14, spine surgeon consultation was recommended. The provider planned to start decreasing the Norco from 2 a day to 1 a day which upset her. She stated she may just start getting the Soma from the primary care physician. She stated that she tries to do home exercises but her brain does not tell her when she was having increased pain and afterward she has significant debilitating pain. She reported that she had 3

epidural steroid injections in the past and they did nothing and she did not want any more. She stated that Tizanidine, Oxycodone, Diazepam, and Soma helped decrease her pain and spasm. The Soma was also decreased. She was told to stop the Soma after that visit. On 08/07/14, physical therapy with traction was recommended. She was still taking Oxycodone, Tizanidine, Diazepam, Lyrica, Soma, Promethazine, and Lidoderm patches. It is not clear which of the medications were refilled. She reported that she had developed RSD in the left shin and ankle. A spinal surgery consultation had been approved but had not occurred. She complained of urinary and bowel incontinence that mainly happened when the back pain was severe. Her most recent urine drug screen was positive for oxycodone which was consistent with her medication. She was taking Oxycodone, Tizanidine, Diazepam, Lyrica, Soma, Promethazine, and Lidoderm patches and was using a wheeled walker. She described cramping in her leg with seated straight leg raise but it wasn't clear whether she had radicular symptoms. An MRI in December 2012 showed L4-5 bilateral extraforaminal herniated disc with left L4 nerve root involvement. MRI from December 14, 2013 showed a right-sided eccentric disc bulge at L4-5 with moderate narrowing of both neural foramina. There was a right-sided disc protrusion at L3-4. She was advised to try yoga.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Valium 10mg (Retro Dispensed 08/07/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, Page(s): 54.

Decision rationale: The history and documentation do not objectively support the request for Valium 10 mg dispensed on 08/07/14 with unknown frequency and duration. The MTUS state "benzodiazepines (Alprazolam) are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks." In this case, the claimant's pattern of use of Valium is unknown and the measurable objective benefit to her and evidence of sustained functional improvement have not been described. There is no evidence that the claimant has been involved in an ongoing exercise program to try to maintain any benefit she receives from treatment measures. The medical necessity of this request for Valium 10 mg has not been clearly demonstrated. The MTUS do not support its use for chronic conditions. The request is not medically necessary.

Soma 350mg (Retro Dispensed 08/07/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines July 18 2009 Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol, page 60: Medications for Chronic Pain, Page(s): 94.

Decision rationale: The history and documentation do not objectively support the request for Soma 350 mg dispensed on 08/07/14 with unknown frequency and duration. The MTUS state Carisoprodol is "not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Carisoprodol is now scheduled in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. In regular abusers the main concern is the accumulation of meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. This includes the following: a)increasing sedation of benzodiazepines or alcohol; b)use to prevent side effects of cocaine; c)use with tramadol to produce relaxation and euphoria; d)as a combination with hydrocodone, an effect that some abusers claim is similar to heroin (referred to as a "Las Vegas Cocktail"); & e)as a combination with codeine (referred to as "Soma Coma"). (Reeves, 1999) (Reeves, 2001) (Reeves, 2008) (Schears, 2004) There was a 300% increase in numbers of emergency room episodes related to Carisoprodol from 1994 to 2005. (DHSS, 2005) Intoxication appears to include subdued consciousness, decreased cognitive function, and abnormalities of the eyes, vestibular function, appearance, gait and motor function. Intoxication includes the effects of both Carisoprodol and meprobamate, both of which act on different neurotransmitters. (Bramness, 2007) (Bramness, 2004) A withdrawal syndrome has been documented that consists of insomnia, vomiting, tremors, muscle twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. This is similar to withdrawal from meprobamate. (Reeves, 2007)"Additionally, MTUS state "relief of pain with the use of medications is generally temporary and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication." In this case, there is no documentation of significant benefit to the claimant from the use of this medication, although she states it helps. The claimant's pattern of use of this medication is unclear and there is no objective measurable evidence of functional improvement based on the use of Soma. There is no indication that she is involved in an ongoing exercise program to help her to maintain any benefit she receives from treatment measures. The medical necessity of ongoing use of Soma 350 mg with unknown frequency and duration for her chronic complaints has not been clearly demonstrated.

Oxycodone 30mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : Opioids for Chronic Pain, page 110; Medications for Chronic Pain, Page(s): 94, 110.

Decision rationale: The history and documentation do not objectively support the request for the opioid, oxycodone 30 mg with unknown frequency, duration, and quantity. The MTUS outlines several components of initiating and continuing opioid treatment and states "a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." In these records, there is no documentation of trials and subsequent failure of or intolerance to first-line drugs such as acetaminophen or nonsteroidal anti-inflammatory drugs. The MTUS further explains, "pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts." There is no indication that periodic monitoring of the claimant's pattern of use and response to this medication, including assessment of pain relief and functional benefit, has been or will be done. There is no evidence that she has been involved in an ongoing rehab program to help maintain any benefits she receives from treatment measures. Additionally, the 4A's "analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors" should be followed and documented per the guidelines. The claimant's pattern of use of oxycodone is unclear including her pain levels before and after use and the duration of relief along with her level of functionality before and after each dose. There is no evidence that a pain diary has been recommended and is being kept by the claimant and reviewed by the prescriber. She reports benefit from medication use in general without specific descriptions of the benefit she gets from this medication. As such, the prescription for oxycodone 30 mg is not medically necessary.

Zanaflex 4mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 47.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxers Page(s): 97.

Decision rationale: The history and documentation do not objectively support the request for the use of Zanaflex 4mg with unknown frequency, duration, and quantity. The MTUS state "muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving." Additionally, MTUS ODG state "relief of pain with the use of medications is generally temporary and measures of the lasting benefit from this modality should

include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. A record of pain and function with the medication should be recorded. (Mens 2005) Additionally, the medical records provided do not provide objective findings of acute spasms or a diagnosis of acute spasm. In this case, the claimant's history of trials of other first-line drugs such as acetaminophen and anti-inflammatories and local modalities such as ice and heat and any response to them, including relief of symptoms and documentation of functional improvement, have not been described. It is not clear why more than one muscle relaxant medication has been recommended (she was also given diazepam and Soma). It is not clear what specific benefit she gets from the use of Zanaflex and as such, this request for Zanaflex 4 mg is not medically necessary.