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| Case Number: | CM14-0163273 | | |
| Date Assigned: | 10/08/2014 | Date of Injury: | 06/06/2006 |
| Decision Date: | 10/13/2015 | UR Denial Date: | 09/03/2014 |
| Priority: | Standard | Application Received: | 10/03/2014 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: North Carolina

Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

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

This is a 59 year old female with a date of injury of June 6, 2006. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar disc disorder, lumbar facet syndrome, knee pain, and mood disorder. Medical records dated July 31, 2014 indicate that the injured worker complains of lower back pain and bilateral knee pain that has increased since the last visit. Records also indicate complaints of pain radiating from the buttock down the right leg, and that the injured worker had difficulty getting out of her chair. A progress note dated June 5, 2014 notes subjective complaints of lower back pain and bilateral knee pain that has increased since the last visit. Per the treating physician (July 31, 2014), the employee was permanent and stationary. The physical exam dated July 31, 2014 reveals restricted range of motion of the lumbar spine (flexion of 50 degrees limited by pain, extension of 10 degrees limited by pain, right lateral bending of 20 degrees, left lateral bending of 20 degrees, lateral rotation to the left to 25 degrees, lateral rotation to the right of 25 degrees limited by pain), tenderness to palpation of the lumbar paravertebral muscles bilaterally, positive lumbar facet loading on the right, deep buttock pain with internal rotation of the femur and tenderness over the right piriformis. The progress note dated June 5, 2014 documented a physical examination that showed restricted range of motion of the lumbar spine (flexion of 50 degrees limited by pain, extension of 10 degrees limited by pain, right lateral bending of 20 degrees, left lateral bending of 20 degrees, lateral rotation to the left to 25 degrees, lateral rotation to the right of 25 degrees limited by pain), tenderness to palpation of the lumbar paravertebral muscles bilaterally, positive lumbar facet loading on the right, deep buttock pain with internal rotation of the femur

and tenderness over the right piriformis. Treatment has included medications (Ibuprofen, Norco 10-325mg one daily as needed, Neurontin 300mg one twice a day, Zanaflex 4mg one twice a day as needed, Valium, and Clonazepam since at least March of 2014), home exercise, and activity restrictions (no lifting greater than 25 pounds, no pushing or pulling greater than 40 pounds, limited standing and walking, and limited repetitive bending and twisting). The treating physician documented (July 31, 2014) that the Neurontin reduced radicular pain levels from 8 of 10 to 4 out of 10, the Zanaflex reduces pain and spasms from 10 out of 10 to 7 out of 10, and that "There is no evidence of misuse of pain medications". The original utilization review (September 3, 2014) partially certified a request for Zanaflex 4mg #60, Norco 10-325mg #30, and Neurontin 300mg #60 (original request for Zanaflex 4mg #60 with 1 refill, QTY: 120, Norco 10-325mg #30 with 1 refill, QTY:60, and Neurontin 300mg #60 with 1 refill, QTY:120).

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4mg #60 with 1 refill, QTY: 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The California chronic pain medical treatment guidelines section on muscle relaxants states: 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) (Chou, 2004) This medication is not intended for long-term use per the California MTUS. The medication has not been prescribed for the flare-up of chronic low back pain. This is not an approved use for the medication. For these reasons, criteria for the use of this medication have not been met. Therefore the request is not medically necessary.

Norco 10-325mg #30 with 1 refill, QTY: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a)

Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. 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. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor- shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids: (a) If the patient has returned to work; (b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004). The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function. Therefore not all criteria for the ongoing use of opioids have been met and the request is not medically necessary.

Neurontin 300mg #60 with 1 refill, QTY: 120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-epilepsy drugs (AEDs).

Decision rationale: The California chronic pain medical treatment guidelines section on Neurontin states: Gabapentin (Neurontin, Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. (Backonja, 2002)

(ICSI, 2007) (Knotkova, 2007) (Eisenberg, 2007) (Attal, 2006) This RCT concluded that gabapentin monotherapy appears to be efficacious for the treatment of pain and sleep interference associated with diabetic peripheral neuropathy and exhibits positive effects on mood and quality of life. (Backonja, 1998) It has been given FDA approval for treatment of post-herpetic neuralgia. The number needed to treat (NNT) for overall neuropathic pain is 4. It has a more favorable side-effect profile than Carbamazepine, with a number needed to harm of 2.5. (Wiffen2-Cochrane, 2005) (Zaremba, 2006) Gabapentin in combination with morphine has been studied for treatment of diabetic neuropathy and post-herpetic neuralgia. When used in combination the maximum tolerated dosage of both drugs was lower than when each was used as a single agent and better analgesia occurred at lower doses of each. (Gilron-NEJM, 2005) Recommendations involving combination therapy require further study. The patient has the diagnosis of neuropathic pain in the form of radiculopathy. Therefore the request is medically necessary and approved.