

Case Number:	CM13-0008678		
Date Assigned:	03/24/2014	Date of Injury:	12/14/2008
Decision Date:	04/22/2014	UR Denial Date:	06/20/2013
Priority:	Standard	Application Received:	08/08/2013

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 Physical Medicine & Rehabilitation 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:

This 53 year-old male furniture salesman sustained a low back injury after unloading a recliner into a truck on 12/14/08 while employed by [REDACTED]. Requests under consideration include ALPRAZOLAM 0.5 MG and OXYCODONE 30 MG. Diagnoses included Chronic low back pain; failed back surgery syndrome; bilateral lumbar radiculopathy; spinal cord stimulator with incomplete efficacy; moderately high opiate tolerance. Pre-injury history include prior MVA in 1990's with neck pain; L2-L4 lumbar fusion on 3/6/03; chronic low back pain; knee injury; rheumatic heart fever; major depressive disorder and insomnia; s/p bilateral carpal tunnel release; and sinus surgery. On the injury date, he presented to the emergency department for low back pain. He was assessed with lumbar muscle spasm and Valium was added to his previous medications of Vicodin, Methadone, Xanax, and Trazodone. He subsequently underwent L4-5 decompressive laminectomy and L2-4 hardware removal on 9/1/09. The patient is also s/p spinal cord stimulator trial placement on 1/6/11. Report of 12/8/11 noted the patient on Soma, Alprazolam and Oxycodone. Report of 3/26/13 from the provider noted the patient with spinal cord stimulator with incomplete efficacy; moderately high opiate tolerance; failed back surgery; and bilateral lumbar radiculopathy and chronic low back pain. The patient remained P&S; Medications were refilled to include Alprazolam, Oxycodone, Soma, Oxymorphone ER (last filled 5/20/13), Baclofen, Trazodone, and topical Androgel. The requests for Alprazolam was partially certified on 6/20/13 for 3 months to taper and Oxycodone for 6 months to discontinue citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

ALPRAZOLAM 0.5MG: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
BENZODIAZEPINES Page(s): 24.

Decision rationale: This 53 year-old male furniture salesman sustained a low back injury after unloading a recliner into a truck on 12/14/08 while employed by [REDACTED]. Requests under consideration include ALPRAZOLAM 0.5 MG and OXYCODONE 30 MG. Diagnoses included Chronic low back pain; failed back surgery syndrome; bilateral lumbar radiculopathy; spinal cord stimulator with incomplete efficacy; moderately high opiate tolerance. Pre-injury history include prior MVA in 1990's with neck pain; L2-L4 lumbar fusion on 3/6/03; chronic low back pain; knee injury; rheumatic heart fever; major depressive disorder and insomnia; s/p bilateral carpal tunnel release; and sinus surgery. On the injury date, he presented to the emergency department for low back pain. He was assessed with lumbar muscle spasm and Valium was added to his previous medications of Vicodin, Methadone, Xanax, and Trazodone. He subsequently underwent L4-5 decompressive laminectomy and L2-4 hardware removal on 9/1/09. The patient is also s/p spinal cord stimulator trial placement on 1/6/11. Report of 12/8/11 noted the patient on Soma, Alprazolam and Oxycodone. Report of 3/26/13 from the provider noted the patient with spinal cord stimulator with incomplete efficacy; moderately high opiate tolerance; failed back surgery; and bilateral lumbar radiculopathy and chronic low back pain. The patient remained P&S; Medications were refilled to include Alprazolam, Oxycodone, Soma, Oxymorphone ER (last filled 5/20/13), Baclofen, Trazodone, and topical Androgel. The requests for Alprazolam was partially certified on 6/20/13 for 3 months to taper and Oxycodone for 6 months to discontinue citing guidelines criteria and lack of medical necessity. Xanax (Alprazolam) is indicated for the management of anxiety disorder. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Alprazolam is an anti-anxiety medication in the benzodiazepine family which inhibits many of the activities of the brain as it is believed that excessive activity in the brain may lead to anxiety or other psychiatric disorders. Per the Chronic Pain Treatment Guidelines, benzodiazepines 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 as chronic benzodiazepines are the treatment of choice in very few conditions and tolerance to hypnotic effects develops rapidly. Additionally, submitted reports have not demonstrated clear functional benefit of treatment already rendered. The ALPRAZOLAM 0.5 MG is not medically necessary and appropriate.

OXYCODONE 30MG: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

Decision rationale: This 53 year-old male furniture salesman sustained a low back injury after unloading a recliner into a truck on 12/14/08 while employed by [REDACTED]. Requests under consideration include ALPRAZOLAM 0.5 MG and OXYCODONE 30 MG. Diagnoses included Chronic low back pain; failed back surgery syndrome; bilateral lumbar radiculopathy; spinal cord stimulator with incomplete efficacy; moderately high opiate tolerance. Pre-injury history include prior MVA in 1990's with neck pain; L2-L4 lumbar fusion on 3/6/03; chronic low back pain; knee injury; rheumatic heart fever; major depressive disorder and insomnia; s/p bilateral carpal tunnel release; and sinus surgery. On the injury date, he presented to the emergency department for low back pain. He was assessed with lumbar muscle spasm and Valium was added to his previous medications of Vicodin, Methadone, Xanax, and Trazodone. He subsequently underwent L4-5 decompressive laminectomy and L2-4 hardware removal on 9/1/09. The patient is also s/p spinal cord stimulator trial placement on 1/6/11. Report of 12/8/11 noted the patient on Soma, Alprazolam and Oxycodone. Report of 3/26/13 from the provider noted the patient with spinal cord stimulator with incomplete efficacy; moderately high opiate tolerance; failed back surgery; and bilateral lumbar radiculopathy and chronic low back pain. The patient remained P&S; Medications were refilled to include Alprazolam, Oxycodone, Soma, Oxymorphone ER (last filled 5/20/13), Baclofen, Trazodone, and topical Androgel. The requests for Alprazolam was partially certified on 6/20/13 for 3 months to taper and Oxycodone for 6 months to discontinue citing guidelines criteria and lack of medical necessity. Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance with change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in work status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain. OXYCODONE 30 MG is not medically necessary and appropriate.