

Case Number:	CM13-0058387		
Date Assigned:	12/30/2013	Date of Injury:	11/10/2009
Decision Date:	03/26/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	10/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Pulmonary Diseases 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 physician 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 patient is a 62 year old female who reported an injury on 11/10/2009. The patient has reportedly been treated for ongoing low back problems and eventually underwent a fusion of the L1-4 levels in 2008. The patient had modest relief but the back pain eventually got worse within 3 months and the right leg pain was consistent. It was noted that after the patient followed up, the physician found that the instrumentation was protruding through the patient's back, whereupon the patient was sent with a fusion at the T10-L4 allegedly since the earlier hardware "had torn the spine." The patient was seen on 11/07/2013 whereupon it was noted she was taking Norco, tizanidine, gabapentin, and Trazodone. The patient had reportedly not had any more epidurals since her first surgery in 2008. Her present complaints consist of pain in the lumbar and lower thoracic spine with a pulling when she flexes her neck, absent of any clear tingling. The patient does feel numbness and achiness over the right leg and experiences cramping in the right foot. The patient most recently had electrodiagnostic studies performed on 12/13/2013 due to persistent low back pain with right and left referred symptoms of both chronic aches to occasional shooting discomfort. Findings from that exam noted benign appearing EMG/NCV of the lower extremities, with no clear acute or apparent chronic axonal motor root (L5 or L4 or other) evidence. There was no confounding compression neuropathy such as sciatic nerve/piriformis, peroneal, or other entrapments and no polyneuropathy noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: According to California MTUS Guidelines, repeated use of opioids can sometimes end up leading to sensitization and can even increase pain over time with extended use. In the case of this patient, the documentation notes that she has been utilizing Norco since at least 10/2012. However, the current documentation provided for review does not give a thorough rationale for the use of this medication. The documentation lacks information pertaining to the efficacy of the use of this medication as it relates to the patient's functional abilities and decreasing her discomfort. There are no quantitative measurements providing objective measurements of pain status throughout the documentation to monitor the efficacy of this medication. Furthermore, there is no documentation providing urine drug screens for monitoring purposes of compliance with the medication use. Therefore, the requested service is not deemed medically appropriate without having sufficient information regarding efficacy and patient compliance. Therefore, the requested service is non-certified.

Tizanidine 4mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: According to California MTUS Guidelines, tizanidine is a centrally acting alpha 2 adrenergic agonist that is FDA approved for management of spasticity. However, there is unlabeled use for low back pain. The patient has been utilizing this medication since 10/2012. Although the documentation indicates the patient has had ongoing chronic back pain throughout her lumbar and thoracic spine, the most current documentation does not provide any information pertaining to the efficacy of this medication nor its use in increasing her functional abilities. There is a lack of objective information regarding how the patient's pain levels and range of motion are positively affected from the use of this medication. Therefore, the requested service is not deemed medically necessary and is non-certified.

Gabapentin 800mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-17.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin®) Page(s): 49.

Decision rationale: According to California MTUS Guidelines, this medication has been shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has also been considered as a first line treatment for neuropathic pain. In the case of this patient, she has been utilizing gabapentin for complaints of chronic back pain since at least 10/2012. However, the current documentation provided for review does not given any indication as to the use of this medication nor its efficacy in treating the patient. There are no objective/quantitative measurements pertaining to the patient's level of pain or functional deficits without the use of this medication. Therefore, the continuation of its use cannot be established. As such, the requested service is non-certified.

Trazodone 200mg, #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental and Stress Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental and Stress Chapter, Trazodone (Desyrel).

Decision rationale: According to California MTUS Guidelines, antidepressants can be used for a first line treatment for neuropathic pain, and a possibility for nonneuropathic pain. Under Official Disability Guidelines, trazodone is recommended as an option for insomnia, but only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. In the case of this patient, the documentation does not give a thorough overview of the use of this medication. It is unclear if it is being used to treat depression, anxiety, or used for overall pain purposes. The current documentation does not provide any information pertaining to the efficacy of this medication nor its intended use; therefore, the rationale for the continuation of its use cannot be established. As such, the requested service is not deemed medically necessary and is non-certified.