

Case Number:	CM13-0068855		
Date Assigned:	01/03/2014	Date of Injury:	04/22/2010
Decision Date:	05/28/2014	UR Denial Date:	12/13/2013
Priority:	Standard	Application Received:	12/20/2013

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 Texas. 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 injured worker reported an injury on 04/22/2010. The mechanism of injury was not stated. Current diagnoses include myofascial pain syndrome, facet arthropathy of the lumbar spine, and lumbar disc herniations. The injured worker was evaluated on 11/21/2013. The injured worker reported persistent neck and back pain, rated 8/10. Current medications included Norco 10/325 mg, Zanaflex 4 mg, Elavil 25 mg, Prilosec 20 mg, and Motrin 800 mg. Physical examination revealed decreased range of motion of the lumbar spine, positive facet loading maneuver at L5- S1, decreased sensation in the L4-S1 dermatomes on the right, and decreased sensation at C5-7 on the left. Treatment recommendations at that time included continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

HYDROCODONE/APAP 10/325MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized hydrocodone 10/325 mg since 01/2013. There is no documentation of objective functional improvement as a result of the ongoing use of this medication. There is also no frequency or quantity listed in the current request. Therefore, the request for Hydrocodone/APAP 10/325mg is not medically necessary and appropriate.

ZANAFLEX 4MG #90: Upheld

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

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

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second-line options for short-term treatment of acute exacerbations. The injured worker has utilized Zanaflex 4 mg since 01/2013. There is no evidence of objective functional improvement. Guidelines do not recommend long-term use of this medication. There is also no frequency listed in the current request. Therefore, the request for Zanaflex 4mg #90 is not medically necessary and appropriate.