

Case Number:	CM13-0071212		
Date Assigned:	01/08/2014	Date of Injury:	11/10/2008
Decision Date:	04/22/2014	UR Denial Date:	12/23/2013
Priority:	Standard	Application Received:	12/26/2013

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 Anesthesiology, 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 patient is a 36 year-old male with a date of injury of 11/10/08. The patient's diagnoses include chronic low back pain, lumbar radiculopathy, depression, and anxiety. On 5/19/12, this patient had an L3-S1 fusion. There is documentation from 3/18/13 noting persistent low back pain without improvement with the pain rated as an 8/10. On 12/9/13, there is a medical note stating this patient continues to have low back pain with radiation to bilateral lower extremities. The radicular pain is reportedly worse. Percocet is reported to help with the pain, affording four hours of relief. Zanaflex is prescribed to help with reduction in muscle spasms which are noted to be increased in the lower extremities. Elavil is noted to improve restlessness and insomnia. Lower extremity EMG and nerve conduction studies were performed on 6/18/13. The conclusion of these studies was abnormal, consistent with chronic neuropathic changes bilaterally at L4, L5 and S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 ELAVIL 10MG: Overturned

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 Page(s): 13-15.

Decision rationale: Elavil is a tricyclic antidepressant. MTUS guidelines recommend this as a first line pain treatment. Tricyclic antidepressants are noted to be effective in the treatment of low back pain and are also an option in radiculopathy. MTUS guidelines also recommend tricyclic antidepressants as first line treatment of neuropathic pain. This patient has a diagnosis of low back pain with radiculopathy. There is also documented evidence of chronic neuropathic changes and abnormalities of EMG/NCS. Tricyclic antidepressants are recommended as first line treatment according to MTUS guidelines. Therefore, the above listed treatment is considered to be medically necessary.

90 ZANAFLEX 2MG: 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 Page(s): 66.

Decision rationale: Zanaflex is an alpha-2 agonist and short acting muscle relaxant used for the treatment of spasticity. According to MTUS guidelines, there are a few studies demonstrating efficacy in the treatment of low back pain. Because of the association of Zanaflex and hepatotoxicity, MTUS guidelines recommend monitoring liver function tests at regular three month intervals. There is documented evidence of a prescription for Zanaflex in 2013, dating back at least several months. There is no documented evidence of monitoring of liver function tests at baseline or anytime thereafter. For this reason, the above requested treatment is considered not medically necessary.

150 PERCOCET 7.5/325MG: 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 Page(s): 74-97.

Decision rationale: This patient has documented evidence of chronic low back pain. Percocet is a short acting opioid combined with acetaminophen. MTUS Guideline recommendations state that opioids appear to be efficacious but limited for short-term pain relief, and long term efficacy is unclear (> 16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no clearly documented evidence of reassessment and consideration of alternative therapy. In addition, MTUS guidelines state that pain assessment should include current pain, the least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. In addition, the guidelines state that actions should also include continuing review of the overall situation with regard to nonopioid means of pain control, and 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 three months. There is no documented evidence of intensity of pain after taking opioid, how long it takes for pain relief, or how long pain lasts. Therefore, the above requested treatment is considered not medically necessary.