

Case Number:	CM14-0103954		
Date Assigned:	07/30/2014	Date of Injury:	06/06/2006
Decision Date:	09/09/2014	UR Denial Date:	06/18/2014
Priority:	Standard	Application Received:	07/07/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Oklahoma and 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 is a 51-year-old who reported injury on June 6, 2006. The mechanism of injury, diagnostic studies and prior treatments were not provided. The documentation indicated the injured worker had low back pain and bilateral leg pain. The pain was stabbing in the low back radiating to the hips. The injured worker had associated symptoms of numbness, tingling and burning down to both feet and legs to the posterior thigh and posterior calf over the top of the foot, left greater than right. The current medications were noted to include Norco 10/325 mg, 4 to 5 tablets per day and Prilosec 20 mg, 2 tablets daily as well as Ambien 1 to 1 and a half tablets, lorazepam 1.5 tablets twice a day as needed for sleep. The injured worker indicated he had increased pain since the last visit. The physical examination revealed the injured worker had diminished sensation of the L4, L5 and S1 dermatomes. The CURES report was consistent. The urine drug screen was positive for Oxycodone opiates and benzodiazepines. The physician documented if the oxycodone was positive there would be a stopping of the controlled substances. The diagnoses included status post transforaminal lumbar interbody fusion at L5-S1 February 7, 2012, stenosis of the lumbar spine and lumbar radiculopathy. The treatment plan included a transforaminal epidural steroid injection, Norco 10/325 mg, 1 tab by mouth q6 hours as needed #120, Prilosec 20 mg twice a day for GI upset and number 1 Docuprene 100 mg tablets #60 as well as Zanaflex 4 mg tablets, 1 tablet per day as needed for spasms. The DWC form RFA was submitted for the requested services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325 mg 120 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain,ongoing management,opioid dosing Page(s): 60, 78, 86.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, and objective decrease in pain in documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and an objective decrease in pain. There was documentation the injured worker was being monitored for aberrant drug behavior and side effects. The duration of use could not be established through supplied documentation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Hydrocodone/APAP 10/325 mg, 120 count is not medically necessary or appropriate.

Zanaflex 4 mg thirty count: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute pain. Their recommendation is recommended for less than 3 weeks. The duration of use could not be established through supplied documentation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Zanaflex 4 mg thirty count is not medically necessary or appropriate.