MAXIMUS Federal Services

Case Number:	CM14-0104827		
Date Assigned:	07/30/2014	Date of Injury:	10/05/2009
Decision Date:	09/10/2014	UR Denial Date:	06/23/2014
Priority:	Standard	Application Received:	07/08/2014

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 Anesthesiology and Pain Medicine, and is licensed to practice in Florida. 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 53-year-old female who reported an injury on 10/05/2009 due to lifting a heavy object. The injured worker reportedly sustained an injury to her cervical spine and lumbar spine. The injured worker's treatment history has included lumbar fusion, physical therapy, epidural steroid injections and medications. The injured worker was monitored for aberrant behavior with urine drug screens. The injured worker was evaluated on 06/12/2014. It was noted that the injured worker had continued cervical spine pain radiating into the bilateral upper extremities and continued low back pain that radiated into the bilateral lower extremities. The injured worker's medications were noted to be Norco 7.5/325 mg, Zofran 8 mg, cyclobenzaprine 10 mg, Effexor XR 150 mg, Ambien 10 mg, Fioricet 50/300/40 mg and Estradiol 1 mg. Physical findings of the cervical spine included tenderness to palpation of the paravertebral musculature with limited range of motion secondary to pain. Evaluation of the lumbar spine revealed tenderness to palpation of the paravertebral musculature with restricted range of motion secondary to pain and a positive straight leg raising test. The injured worker's diagnoses included lumbago, thoracic/lumbosacral neuritis/radiculitis, brachial neuritis or radiculitis, cervicalgia, intervertebral lumbar disc disease without myelopathy, intervertebral cervical disc disease without myelopathy of the cervical spine, degenerative lumbar/lumbosacral intervertebral disc disease, degeneration of the cervical intervertebral discs. A request was made for a refill of medications. However, a Request for Authorization was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine HCL 10 mg Tabs 1 po q 8 prn #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmotics Page(s): 64.

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

Decision rationale: The requested cyclobenzaprine hydrochloride 10 mg tablets by mouth every 8 hours as needed #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of muscle relaxants for short durations of treatment, not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation submitted for review indicates that the injured worker has been using this medication since at least 04/2014. This, in combination with the requested medication exceeds guideline recommendations. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. As such, the requested cyclobenzaprine hydrochloride 10 mg tablets 1 by mouth every 8 hours as needed #90 is not medically necessary or appropriate.

Norco 7.5/ 325mg Tabs: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, page(s) 78 Page(s): page(s) 78.

Decision rationale: The requested Norco 7.5/325 mg tablets is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, evidence of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker is monitored for aberrant behavior. However, a quantitative assessment to support pain relief or documentation of functional benefit was not provided. Therefore, ongoing use of this medication is not supported. Furthermore, the request as it is submitted does not clearly identify a quantity, or frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested Norco 7.5/325 mg tablets is not medically necessary or appropriate.

Hydrocodone-Acetaminophen 1 po Q6hrs prn pain #120 (2 Refills): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, page(s) 78 Page(s): page(s) 78.

Decision rationale: The requested hydrocodone/acetaminophen 1 every 6 hours as needed for pain #120 with 2 refills is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documented functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the injured worker is monitored for aberrant behavior with urine drug screens. However, the clinical documentation does not provide a quantitative assessment of pain relief or specific functional benefit resulting from medication usage. Also, the request includes 2 refills. This does not allow for timely re-evaluation and documentation to support ongoing use. Furthermore, the request as it is submitted does not clearly identify a dosage. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested hydrocodone/acetaminophen 1 by mouth every 6 hours as needed for pain #120 with 2 refills is not medically necessary or appropriate.

Zofran ODT 8 mg TBDT 1 po BID prn #60 (2 refills): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability guidelines-Treatment for Workers Compensation, Online Edition Chapter Pain (chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Anti-ememtics.

Decision rationale: The requested Zofran ODT 8 mg TBDT 1 by mouth twice a day as needed #60 with 2 refills is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines do not recommend antiemetics to assist with management of nausea and vomiting related to medications. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's gastrointestinal system to support that the injured worker is experiencing a case of acute gastritis. Therefore, the need for this medication is not clearly indicated. As such, the requested Zofran ODT 8 mg TBDT one by mouth twice a day as needed #60 with 2 refills is not medically necessary or appropriate.