

Case Number:	CM14-0107837		
Date Assigned:	08/01/2014	Date of Injury:	03/03/2012
Decision Date:	10/01/2014	UR Denial Date:	06/16/2014
Priority:	Standard	Application Received:	07/11/2014

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 & Rehabilitation and is licensed to practice in Texas and Ohio. 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 55 year old male who reported injury on 03/03/2012. The mechanism of injury was not provided. Diagnoses included history of L1 compression fracture in 1988, right peroneal neuropathy, and possible lumbar radiculopathy. The past treatments included physical therapy and home exercise. A CT scan of the lumbar spine revealed multilevel degenerative disc disease. Surgical history noted an L5-S1 laminectomy, foraminotomy, and discectomy on 10/09/2013. The progress note dated 05/27/2014, noted the injured worker complained of pain averaging 3-6/10. The injured worker was ambulating with a cane and there was tenderness to palpation noted to the low back. Medications included Lidoderm, Norco 10/325 4 per day, and Tizanidine 4 mg 3-4 per day. It was noted, the injured worker stopped taking Percocet, Neurontin, Effexor and amitriptyline. The treatment plan included a recommendation for continuation of medications. The Request for Authorization form was dated 06/09/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patches #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm, Page(s): 56-57.

Decision rationale: The request for Lidoderm patches #30 is not medically necessary. The injured worker had unspecified, unmeasured pain, with tenderness to palpation of the low back. The California MTUS guidelines recommend Lidoderm for neuropathic pain with localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica), and is not recommended for non-neuropathic pain. There was no documentation of the quality or severity of pain. There was no documentation demonstrating Neurontin, Effexor or amitriptyline failed to relieve the injured worker's pain. Additionally, the request does not indicate the frequency at which the medication is prescribed, the dosage at which the medication is prescribed, and the location intended for use in order to determine the necessity of the medication. Due to the lack of documentation of localized neuropathic pain, or failure of first line medications, and the exclusion of the location intended for use, the use of Lidoderm patches is not supported. Therefore, the request is not medically necessary

Retrospective Norco 10/325mg # 120 (DOS 5/27/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Opioids Page(s): 78-81.

Decision rationale: The retrospective request for Norco 10/325mg #120 is not medically necessary. The injured worker had unspecified, unmeasured pain, with tenderness to palpation of the low back. The California MTUS guidelines recommend opioids as second-line treatment of moderate to moderately severe pain, and for long term management of chronic pain when pain and functional improvements are documented. Adverse side effects and aberrant drug taking behaviors should also be assessed for ongoing management of opiates. There was no documentation of the quality or severity of pain. The requesting physician did not provide documentation of an adequate and complete assessment of the injured worker's pain. There was no measurement of the efficacy of the opioid medication. There was no noted assessment of aberrant behavior. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The intended frequency was not documented. Due to the lack of evidence of measured improvement with the opioid medication, no documentation of appropriate drug use, and the exclusion of the frequency intended for use, the use of Norco is not supported at this time. Therefore, the request is not medically necessary.

Retrospective Tizanidine 4mg #90 (DOS 5/27/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Page(s): 64-66.

Decision rationale: The retrospective request for Tizanidine 4 mg #90 is not medically necessary. The injured worker had unspecified, unmeasured pain, with tenderness to palpation of the low back. The California MTUS guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Tizanidine is FDA approved for the management of spasticity with unlabeled use for low back pain. There was no documentation of the quality or severity of pain. There was no documentation of failure of first line medications. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The requesting physician's rationale for the request is not indicated within the provided documentation. The injured worker has been prescribed Tizanidine since at least 04/29/2014. The continued use of this medication would exceed the guideline recommendation for a short course of treatment. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. Therefore, the request is not medically necessary.