

Case Number:	CM14-0151451		
Date Assigned:	09/19/2014	Date of Injury:	12/05/2012
Decision Date:	11/20/2014	UR Denial Date:	08/21/2014
Priority:	Standard	Application Received:	09/17/2014

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, has a subspecialty in Interventional Spine 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:

The patient is a 51-year-old female with date of injury of 12/05/2012. The listed diagnoses per [REDACTED] from 07/24/2014 are: 1. Status post lumbar laminectomy. 2. Lumbar disk disease. 3. Lumbar radiculopathy. 4. Lumbar facet syndrome. According to this report, the patient complains of lumbar spine pain at a rate of 9/10. It is described as constant, stabbing, sharp, and excruciating radiating pain with associated numbness and tingling sensation in the left toes as well as occasional burning sensation in the right toes. The examination shows the patient is well developed well nourished, in no apparent distress. The patient has an antalgic gait to the left. Heel-to-toe walk is performed without difficulty. There is a well-healed surgical incision noted in the lumbar spine. There is moderate tenderness to palpation over the lumbar paraspinal muscles, moderate facet tenderness to palpation at L4 through S1 levels. Kemp's test and Farfan's test is positive bilaterally. There is no evidence of instability. Sensation is decreased in the right L3 and L4 and left L3, L4, and L5 dermatomal levels. The utilization review denied the request on 08/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #90: 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 Criteria for Use of Opioids; On-Going Management Page(s): 88-89; 78.

Decision rationale: This patient presents with low back pain. The provider is requesting Norco 10/325 mg #90. For chronic opiate use, the MTUS guidelines, pages 88 and 89, on criteria for use of opioids, states, "Pain should be assessed at each visit, and functioning should be measured at six-month intervals using a numerical scale or validated instrument." MTUS, page 78, on ongoing management, also requires documentation of the 4 A's including analgesia, ADLs, adverse side effects, and aberrant drug-seeking behavior, as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioids, time it takes for medications to work, and duration of pain relief. The patient was prescribed Norco on 04/10/2014. The 05/14/2014 report notes, "She particularly reports that her sleep pattern has been adversely affected in a way that she is not able to get a restful night's sleep despite taking medications.... She denies any bladder or bowel dysfunction. She continues to rely on medications, which she states is only minimally helpful and just helps to take the edge off the pain, but does not necessarily give her some long-term relief." The provider does not document medication efficacy, including pain scales, no specifics regarding ADLs, no significant improvement, no mention of quality of life changes, and no discussions regarding "pain assessment" as required by MTUS. In addition, the urine drug screen reports from 02/25/2014 to 04/10/2014 show inconsistent results to prescribed medications. It does not appear that the provider has addressed the patient's inconsistent UDS (urinary drug screenings). Therefore, this request is not medically necessary.

Flexeril 7.5mg #90: 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 Cyclobenzaprine Page(s): 64.

Decision rationale: This patient presents with low back pain. The provider is requesting Flexeril 7.5 mg #90. The MTUS Guidelines, page 64, on cyclobenzaprine, states that it is recommended as a short course of therapy with limited mixed evidence not allowing for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and central nervous system depressant with similar effects to tricyclic antidepressants (amitriptyline). This medication is not recommended to be used for longer than 2 to 3 weeks. The records do not show a history of Flexeril use. In this case, while a trial of Flexeril is reasonable, the requested quantity exceeds MTUS recommended 2- to 3-week treatment period. Therefore, this request is not medically necessary.