

Case Number:	CM14-0154423		
Date Assigned:	09/24/2014	Date of Injury:	09/25/1995
Decision Date:	10/30/2014	UR Denial Date:	09/18/2014
Priority:	Standard	Application Received:	09/22/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 60-year-old male, who reported an injury on 09/25/1995 due to an unknown mechanism. Diagnoses were status post recent right L2-3 hemilaminectomy, history of multiple orthopedic injuries and surgeries of industrial in nature, and chronic pain syndrome with psychological narcotic tolerance. Physical examination, dated 09/09/2014, revealed complaints of ongoing low back pain, multifocal joint pain that included shoulders and both wrists. The injured worker has been psychologically dependent on a regimen of narcotic analgesics for years now without any significant change recently. This regimen has sufficed to get the injured worker through the day, which pain can be reported as 7/10 to 8/10 down to a 3/10 to 4/10. Examination remained unchanged. The lumbar scar was well healed. There was central lumbosacral tenderness. Active voluntary range of motion was guarded in forward flexion and in extension with complaints of stiffness at the extremes of motion. Motor and sensory examinations of the lower extremities were normal. Deep tendon reflexes were 1 to 2+ bilateral infrapatellar and 0 to 1+ bilateral Achilles and symmetrical. Medications were Morphine Sulfate 15mg, Oxycodone 10mg, Lyrica, Zanaflex, and Diazepam. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of lyrica 150mg #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, Page(s): 16.

Decision rationale: The decision for 1 prescription of Lyrica 150mg #60 with 2 refills is not medically necessary. The California Medical Treatment Utilization Schedule states Lyrica is an anticonvulsant that has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has FDA approval for both indications, and is considered first line treatment for both. This medication is designated as a Schedule IV Controlled Substance because of its causal relationship with euphoria. This medication also has an antianxiety effect. Pregabalin is being considered by the FDA as treatment for generalized anxiety disorder and social anxiety disorder. The efficacy for this medication was not reported. The functional improvement for the injured worker was not reported. The request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

1 Prescription of diazepam 10mg #30 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, Page(s): 24.

Decision rationale: The decision for 1 prescription of Diazepam 10mg #30 with 2 refills is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines do not recommend the use of benzodiazepines as treatment for patients with chronic pain for longer than 3 weeks due to a high risk of psychological and physiological dependency. The request does not indicate a frequency for the medication. Clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Therefore, this continued use would not be supported. This request is not medically necessary.

1 Prescription of tizanidine 4mg #60 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine, Page(s): 66.

Decision rationale: The decision for 1 prescription of Tizanidine 4mg #60 with 2 refills is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend Tizanidine (Zanaflex) as a nonsedating muscle relaxant with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The

clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Also, the request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.