MAXIMUS Federal Services

Case Number:	CM14-0024691		
Date Assigned:	06/11/2014	Date of Injury:	06/14/2012
Decision Date:	08/12/2014	UR Denial Date:	01/29/2014
Priority:	Standard	Application Received:	02/26/2014

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 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 59-year-old female with a reported date of injury on 06/14/2012. The mechanism of injury was not submitted within the medical records. Her diagnoses were noted to include lumbar sprain/strain, clinical left lower extremity radiculopathy, status post open reduction and internal fixation to the left hip with residuals, left ankle sprain/strain, and left knee sprain/strain. Her previous treatments were noted to include trigger point injections, medications, epidural steroid injections, physical therapy, and TENS unit. The progress note dated 04/09/2014 revealed the injured worker complained of low back pain radiating down to the bilateral lower extremities. The injured worker rated her pain as 8/10 in intensity with medications and 10/10 in intensity without medications. The injured worker revealed her activities of daily living limitations were limited. The physical examination to the lumbar spine was noted to have spasms and tenderness upon palpation of the spinal vertebral area L2, L4-S1 levels. The range of motion of the lumbar spine was moderately limited secondary to pain. The pain was significantly increased with flexion and extension and the sensory examination revealed decreased sensitivity in both lower extremities as well as decreased strength along the L5-S1 dermatome. Her medications were noted to include gabapentin 600 mg 1/2 tablet by mouth at night, tizanidine 4 mg #30 once daily as needed for spasms, Norco 10/325 mg 1 every 6 hours as needed for pain, and Ambien. The request for authorization form was not submitted within the medical records. The request was for Norco 5/325 mg #90 for pain, Ambien 10 mg #15 for sleep, and tizanidine 4 mg #30 for muscle spasms.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 5-325MG, 90,: Upheld

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

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

Decision rationale: The request for Norco 5/325 mg #90 is not medically necessary. The injured worker has been taking this medication since 09/2013. According to the California Chronic Pain Medical Treatment Guidelines, the ongoing use of opiate medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state that the 4A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors, should be addressed. The injured worker indicated her pain rated 8/10 in intensity with medications and 10/10 in intensity without medications and her pain was reported as worse since her last visit. There is a lack of documentation regarding improved functional status with utilization of this medication. No side effects were noted and a CURES report was ran in 05/2014; however, the documentation provided did not disclose the results. Therefore, despite evidence of some pain relief, there is a lack of documentation regarding increased functional status, side effects, and without details regarding urine drug screening to verify appropriate medication use and the absence of aberrant behaviors, the ongoing use of opioid medications is not supported by the guidelines. Additionally, the request failed to provide the frequency at which this medication is to be utilized. As such, the request is non-certified.

AMBIEN 10MG #15: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain, Zolpidem (Ambien).

Decision rationale: The injured worker has been taking this medication since at least 01/2014. The Official Disability Guidelines recommend zolpidem as a short-acting nonbenzodiazepine hypnotic, which is approved for short-term (usually 2 to 6 weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and is often hard to obtain. While sleeping pills, so called minor tranquilizers and antianxiety agents are commonly prescribed in chronic pain, pain specialist rarely, if ever, recommends them for long-term use. They can be habit forming and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. The guidelines recommend a short-term utilization of this medication and there is a lack of documentation

regarding efficacy. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

TIZANIDINE HCL 4MG #30: 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 (for pain) Page(s): 63.

Decision rationale: The request for tizanidine 4 mg #30 is not medically necessary. The injured worker has been utilizing this medication since at least 01/2014. The California Chronic Pain Medical Treatment Guidelines recommend nonsedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in muscle back pain cases, they show no benefit beyond NSAIDS in pain and overall improvement. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Sedation is the most commonly reported adverse effect of muscle relaxant medications. There is a lack of documentation regarding the efficacy of this medication or improved function. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.