

Case Number:	CM14-0045544		
Date Assigned:	06/27/2014	Date of Injury:	07/08/2009
Decision Date:	08/25/2014	UR Denial Date:	03/20/2014
Priority:	Standard	Application Received:	04/03/2014

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, has a subspecialty in Pain Medicine 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 injured worker is a 55 year old male who had a work related injury on 07/03/09. No documentation of mechanism of injury. Most recent medical record submitted for review dated 03/06/14 the injured worker complained of bilateral low back pain radiating to bilateral lower extremities with numbness and paresthesias, exacerbated by prolonged sitting, standing, lifting, twisting, driving, any activities alleviated by lying supine and pain medication. Physical examination showed well healed scar side of the lumbar surgery. The lumbar range of motion is restricted by pain in all directions. Discogenic provocative maneuvers were positive. Nerve root tension signs were negative bilaterally. Muscle stretch reflexes were symmetrical bilaterally in the lower extremities. Clonus, Babinski, Hoffman signs were absent bilaterally. Muscle strength was 5/5 in bilateral lower extremities, except 4+/5 in left hip flexor. Sensation was decreased to light touch, pin prick, and proprioception, vibration in bilateral L5 dermatomes. Tandem walking was within normal limits and reduced balance in heel and toe walking. Diagnosis is lumbar radiculopathy, lower extremities neuropathic pain, lumbar spasms and failed back surgery. There was no documentation submitted with visual analog scale or functional improvement. He had previous urine drug screen which was consistent.

IMR ISSUES, DECISIONS AND RATIONALES

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

CYCLOBENZAPRINE 10MG 1 TAB PO QD PRN SPASMS #30 X 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN) Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril Page(s): 41. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, muscle relaxant (for pain).

Decision rationale: The request for Cyclobenzaprine 10mg 1 tab every day as needed spasms #30 x 2 refills is not medically necessary. The clinical documentation submitted for review does not support the request. There is no documentation of muscle spasm on physical exam. Recommend non-sedating muscle relaxants with caution as a second-line option for short-term (less than two weeks) treatment of acute low blood pressure (LBP) and for short-term treatment of acute exacerbations in patients with chronic LBP. As such medical necessity has not been established.

GABAPENTIN 300 MG 3 TABS PO QID # 360 X 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AED'S) Page(s): 18,19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Antiepilepsy drugs (AEDs).

Decision rationale: The request for Gabapentin 300mg 3 tabs by mouth four times a day #360 x 2 refills is not medically necessary. The clinical documentation submitted for review does not support the request. There is no documentation of functional improvement, decrease in pain, no visual analog scale scores submitted. As such medical necessity has not been established. However, these medications cannot be abruptly discontinued due to withdrawal symptoms, and medications should only be changed by the prescribing physician.

HYDROCODONE 10/325 MG 1 TAB PO QID PRN FOR PAIN # 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 51,91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioid Page(s): 74-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, opioid's.

Decision rationale: The request for Hydrocodone 10/325mg 1 tab by mouth four times a day as needed for pain #120 is not medically necessary. The clinical documentation submitted for review does not support the request. There is no documentation of functional improvement, decrease in pain, no visual analog scale scores submitted. As such medical necessity has not been established. However, these medications cannot be abruptly discontinued due to withdrawal symptoms, and medications should only be changed by the prescribing physician.

