

Case Number:	CM14-0064837		
Date Assigned:	07/11/2014	Date of Injury:	10/11/2011
Decision Date:	10/07/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/08/2014

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 and is licensed to practice in Nevada. 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 62 year-old female who was reportedly injured on 10/11/2011. The mechanism of injury is noted as an industrial injury. The most recent progress note dated 4/16/2014, indicates that there are ongoing complaints of low back pain that radiates in the right lower extremity with associated foot drop. The physical examination demonstrated lumbar spine: range of motion: flexion 70, extension 20, and lateral flexion 30. Decreased sensation in the right foot and weakness of the right extensor hallucis longus, extensor digitorum communis and anterior tibialis. Deep tendon reflexes are unobtainable no recent diagnostic studies are available for review. Previous treatment includes medications, and conservative treatment. A request was made for hydrocodone 5/500mg Riverside 120 Nortriptyline 10mg #90, Meloxicam 7.5mg #30, Zanaflex 2mg #30, and was not certified in the pre-authorization process on 4/30/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 5/500mg, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use of opioids Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91.

Decision rationale: Hydrocodone/Acetaminophen is a short acting opiate indicated for the management in controlling moderate to severe pain. This medication is often used for intermittent or breakthrough pain. The California Medical Treatment utilization Schedule guidelines support short-acting opiates at the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain; however, there is no objective clinical documentation of improvement in their pain or function with the current regimen. As such, this request for hydrocodone is not medically necessary.

Nortriptyline HCL 10mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13.

Decision rationale: The California Medical Treatment Utilization Schedule supports the use of antidepressants in chronic pain management. Also recommends tricyclics as a first-line agent. Nortriptyline is a tricyclic antidepressant used in the treatment of major depression and childhood nocturnal enuresis. After review the medical records provided there is no documentation that this injured worker has a diagnosis of depression. Therefore this request is deemed not medically necessary.

Meloxicam 7.5mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 72.

Decision rationale: The California Medical Treatment Utilization Schedule supports the use of anti-inflammatories such as meloxicam as a first-line agent for the management of chronic pain. Antiinflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. According to the medical record there is no reports of decrease pain and increased functional activity related directly to the use of medication. Therefore this request for meloxicam is not medically necessary.

Zanaflex 2mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Antispasticity/Antispasmodic Drugs Page(s): 66.

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha 2-adrenergic agonist that is Food and Drug Administration approved for management of spasticity. It is unlabeled for use in low back pain. Muscle relaxants are only indicated as 2nd line options for short-term treatment. It appears that this medication is being used on a chronic basis which is not supported by California Medical Treatment Utilization Schedule treatment guidelines. Therefore, this medication is deemed not medically necessary.