

Case Number:	CM14-0069227		
Date Assigned:	07/14/2014	Date of Injury:	11/17/2010
Decision Date:	09/18/2014	UR Denial Date:	05/01/2014
Priority:	Standard	Application Received:	05/14/2014

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 Texas. 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 32 year old female who reported an injury to her low back and right hip. A clinical note dated 04/15/14 indicated the injured worker complaining of ongoing low back pain with stiffness and spasms rated 8/10 radiating into the lower extremities. Numbness was identified at the right foot along with tingling numbness and tingling were identified at the right foot. A clinical note dated 06/10/14 indicated the injured worker complaining of right lower extremity pain with associated numbness. The injured worker continued to use Norco which was allowing her to be more active. Upon exam, pain was identified throughout the lumbar spine. A clinical note dated 07/08/14 indicated the injured worker complaining of low back pain and right hip pain. Pain radiated into the feet. The current drug regimen provided some benefit. The injured worker described pain as constant and rated 6/10. The injured worker utilized Fexmid and Norco for pain relief. The utilization review dated 08/15/14 resulted in a denial for the use continued use of Fexmid. The utilization review dated 06/10/14 resulted in a denial for the use of cyclobenzaprine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg QTY: 100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Opioids Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 77.

Decision rationale: Injured workers must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of this medication cannot be established at this time.

Fexmid 7.5 mg QTY: 180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Muscle relaxants Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41.

Decision rationale: Cyclobenzaprine is recommended as a second-line option for short-term treatment of acute low back pain and for short-term treatment of acute exacerbations in injured workers with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the injured worker has exceeded the 4 week window for acute management, indicating a lack of efficacy if being utilized for chronic flare-ups. As such, the medical necessity cannot be established at this time.

Right hip x-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Hip and Pelvis Chapter, X-Ray.

Decision rationale: The request for right hip x-ray is non-certified. The injured worker complained of right hip pain. However, no information was submitted regarding functional deficits at the right hip. X-rays are indicated at the hip provided that the injured worker meets specific criteria, including the need to assess severe injuries or the development of osteoarthritis at the hip. No information was submitted regarding acute severe injuries or ongoing development of osteoarthritis. Given this, the request is not indicated as medically necessary.