

Case Number:	CM14-0206122		
Date Assigned:	12/18/2014	Date of Injury:	12/07/2000
Decision Date:	02/11/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	12/09/2014

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 Rehab, has a subspecialty in Interventional spine 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 patient is a 47 year old male with an injury date of 12/07/00. Based on the 01/23/14 progress report, the patient has low back pain and right lower extremity numbness. The 04/22/14 report indicates that the patient complains of low back pain and right leg pain with tingling/numbness. He has slight tension throughout the lower back. Straight leg raise is positive on the right and he has slight decreased sensation at the L5 level on the right. The patient has slight weakness to dorsiflexion on the right as well. The 05/14/14 report states that the patient rates his low back pain as a 7/10. There is pain on the spinous process of L5 and S1, muscle spasm from L2 to L5 of moderate intensity, pain on the facets of L4-5, facet loading being positive more on the right, and a positive Patrick Fabere's. The patient's diagnoses include the following: 1) Post lumbar laminectomy pain syndrome 2) Status post L5-S1 laminectomy on the right side 3) Low back pain with radicular symptoms to the right lower extremity 4) Electrodiagnostic evidence of bilateral L5 radiculopathy study done on 05/03/11 5) MRI findings of 4-5 mm disc protrusion at L5-S1, 4-5 mm disc protrusion at L4-L5 and a 3-4 mm disc protrusion at L3-L4 with multilevel neural foraminal narrowing 6) History of 9 months relief and improvement of radicular symptoms with the epidural injection that was done on 03/27/13 7) Six month history of relief following lumbar epidural done on 02/27/14 The utilization review determination being challenged is dated 11/05/14. Treatment reports were provided from 03/06/13- 09/26/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 4mg #30: Upheld

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

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

Decision rationale: The patient presents with low back pain and right leg pain with tingling/numbness. The request is for Tizanidine 4 mg #30 for sleep and muscle relaxation. The patient has been taking Tizanidine as early as 09/26/13. MTUS Guidelines page 66 allows Zanaflex (Tizanidine) for spasticity, but also for low back pain, myofascial pain, and fibromyalgia. The patient has been taking Tizanidine as early as 09/26/13. The 05/14/14 report states that the patient rates his low back pain as a 7/10. The treater does not specifically discuss the efficacy of Tizanidine on any of the reports provided. There is no discussion as to how this medication has been helpful with pain and function. There is only one general statement regarding the patient's pain scale from 05/14/14. No specific benefits are attributed to the use of Tizanidine. Page 60 of MTUS Guidelines states that when medications are used for chronic pain, recording of pain and function needs to be provided. Therefore, the requested Tizanidine is not medically necessary.

Norco 7.5/325mg #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use of opioids Page(s): 76-78; 88-89.

Decision rationale: The patient presents with low back pain and right leg pain with tingling/numbness. The request is for Norco 7.5/325 mg #90. The patient has been taking Norco as early as 04/22/14. MTUS Guidelines pages 88 through 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or out measures that includes current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. The patient had a urine toxicology screen on 01/27/14 which did not show any evidence of narcotic abuse. The 09/26/14 report states that Norco "helps him do his work activities and function better, decreasing his pain." No further discussions regarding Norco are provided. In this case, the treater documents that the patient is working, with reduced pain due to opiate use. The patient's pain is listed at 7/10 without before and after pain scale to show significant analgesia. The treater states that medication reduces pain, without quantifying the reduction. The treater provides urine toxicology and the patient appears to be compliant. No side effects are noted. The documentations appear to meet MTUS guidelines requirement for chronic opiate use. Given the patient's chronic pain condition including neuropathic and nociceptive pain, the request is medically necessary.

