

Case Number:	CM15-0006889		
Date Assigned:	01/26/2015	Date of Injury:	07/20/2011
Decision Date:	03/19/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	01/13/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 37 year old female sustained a work related injury on 07/20/2011. According to a Qualified Medical Re-evaluation dated 11/15/2014, the injured worker complained of right low back pain with radiation to the right posterolateral buttock down to the right foot with intermittent numbness and tingling in the plantar aspect and lateral three toes and posterior right foot. She also reported stabbing pain in her left hamstring as well as the right ankle. There was pain at the right upper leg. There was numbness and tingling at her right foot as well as the heel. There was swelling of the low back and right hip up to three to four times a week. The injured worker complained of sleep disturbance due to right low back pain. She complained of gastroesophageal reflux disease symptoms and constipation with the use of Norco and naproxen. She also reported that she had difficulties with activities of daily living such as grooming, oral care, toileting, transferring, walking, eating, managing medications, using the telephone and managing money. She only took a shower when someone was home and was dependent on others for performance of housework, doing laundry, shopping and cooking. She had difficulty with driving and climbing stairs. The injured worker reported that she used six to eight Norco tablets per day. According to a progress report approximately 1 weeks early dated 11/04/2014, noted that the injured worker's medication regimen included Naprosyn, Neurontin, Tizanidine and Norco. On 12/08/2014, Utilization Review non-certified Norco 10/325mg #180, Zanaflex 4mg #60 Refills 2, and Naprosyn 200mg #60 Refills 2. In regards to Norco, there was no clear documentation regarding the functional benefit or any substantial functional improvement obtained with the continued use of the narcotic medication. In regards to Zanaflex, based on the

additional clinical information obtained from a conversation with the provider, the medical necessity of the use of Zanaflex was not established. In regards to Naprosyn, there was no indication that the injured worker could not utilize readily available over the counter formulation with similar dosage of this medication required on an as needed basis. Based on the additional clinical information obtained from a conversation with the provider, the medical necessity of the use of Naprosyn was not established. Guidelines cited for this review included CA MTUS Chronic Pain Medical Treatment Guidelines NSAIDS, Opioids and Antispasticity/Antispasmodic Drugs. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: According to the 11/04/2014 report, this patient presents with low back pain and right hip pain. The current request is for Norco 10/325mg #180. The request for authorization is on 11/24/2014. The patient's work status is "remains off of work." For chronic opiate use, MTUS Guidelines pages 88 and 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 aberrant behavior, as well as "pain assessment" or outcome measures that include 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. In reviewing the medical reports provided, there is no mention of this medication usage; it is unknown exactly when the patient initially started taking this medication. In this case, the documentation provided by the treating physician does not show any pain assessment and no numerical scale is used describing the patient's function. No specific ADL's or return to work are discussed. No aberrant drug seeking behavior is discussed, and no discussion regarding side effects is found in the records provided. The treating physician has failed to clearly document the 4 As as required by MTUS. Therefore, the request IS NOT medically necessary and the patient should be slowly weaned per MTUS.

Zanaflex 4 mg #60 with 2 refills: Upheld

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

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

Decision rationale: According to the 11/04/2014 report, this patient presents with low back pain and right hip pain. The current request is for Zanaflex 4mg #60 with 2 refills. The MTUS guidelines page 66, "Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. However, the MTUS guidelines for muscle relaxers only allow a short course of treatment (2-3 weeks) for acute muscle spasms. The documentation provided indicates that this prescription is for long term use which is not supported by MTUS. The treating physician is requesting Zanaflex#60 with 2 refills and there is no mention of this medication usage; it is unknown exactly when the patient initially started taking this medication. The current request IS NOT medically necessary and the recommendation is for denial.

Naprosyn 200 mg #60 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications non-steroidal anti-inflammatory drugs Medications for chronic.

Decision rationale: According to the 11/04/2014 report, this patient presents with low back pain and right hip pain. The current request is for Naprosyn 200mg #60 with 2 refills. The MTUS Guidelines page22 reveal the following regarding NSAIDs, "Anti-inflammatories 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." In reviewing the provided reports, there is no mention of this medication usage; it is unknown exactly when the patient initially started taking this medication. There were no discussions on functional improvement and the effect of pain relief as required by the guidelines. MTUS guidelines page 60 require documentation of medication efficacy when it is used for chronic pain. In this case, there is no mention of how this medication has been helpful in any way. The request IS NOT medically necessary.