MAXIMUS Federal Services

Case Number:	CM15-0102590		
Date Assigned:	06/05/2015	Date of Injury:	06/03/2003
Decision Date:	07/09/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	05/28/2015

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, Hawaii
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:

The injured worker is a 54 year old female who sustained an industrial injury on 06/03/2003. The injured worker was diagnosed with L4-S1 disc degeneration and stenosis, lower extremity radiculopathy, C6-C7 disc displacement and pseudoarthrosis and bilateral sacroiliac (SI) joint dysfunction. The injured worker is status posterior C6-7 anterior cervical decompression and fusion and C6-C7 posterior interbody fusion, ependymoma resection of the conus with improved bowel and bladder function and ventral hernia repairs developing post op. No dates were documented. Treatment to date includes diagnostic testing, surgeries, physical therapy and medications. According to the primary treating physician's progress report on May 14, 2015, the injured worker continues to experience neck pain, which radiates into the interscapular space. The injured worker rates her pain level at 10/10 without medications and 7/10 with medications. The injured worker also reports low back pain radiating into the bilateral lower extremities to the bottom of the feet and bilateral sacroiliac (SI) joint pain, which she rates as 10/10 without medications and 7-8/10 with medications. Examination of the lumbar spine demonstrated normal gait with no evidence of weakness with heel and toe walk. There is no tenderness to palpation of the paravertebral muscles bilaterally. There is tenderness over the sacroiliac (SI) joints bilaterally without tenderness over the sciatic notches, flanks or coccyx. Positive Fortin's sign, positive pelvic compression and positive Gaenslen's sign bilaterally were noted. Motor, sensory and pulses were intact. Straight leg raise was negative bilaterally. Current medications are listed as Neurontin, Percocet, Zanaflex, Miralax and Metamucil. Treatment plan consists of continuing with pain management and the current request for Percocet 10/325mg and Zanaflex.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 mg Qty 180: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The patient presents with pain affecting the upper and lower back. The current request is for Percocet 10/325mg Qty 180. The treating physician states in the report dated 5/14/15, "The patient continues to utilize Percocet 10/325 1 p.o. Q 4 hours which supplies 30% relief from her pain." (19B) For chronic opiate use, the 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 4A's (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 this case, the treating physician has documented that the patient is able to cook and perform other ADLS, has not had any side effects or aberrant behaviors, and the patient is getting pain relief with this medication. The current request is medically necessary.

Zanaflex 4 mg Qty 60: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), Anti-spasticity/Anti-spasmodic Drugs: Tizanidine (Zanaflex, generic available) Page(s): 63-66.

Decision rationale: The patient presents with affecting the upper and lower back. The current request is for Zanaflex 4 mg Qty 60. The treating physician states in the report dated 5/14/15, "She continues to utilize Zanaflex for muscle spasms which helps with the muscle spasms she obtains through muscle guarding of her degenerative lumbar spine." (9B) The MTUS guidelines support Zanaflex for low back pain, myofascial pain and for fibromyalgia. In this case, the treating physician documents that the patient has been dealing with myofascial pain and low back pain and has decreased pain and functional improvement in ADLs with medication usage. The current request is medically necessary.