

Case Number:	CM15-0206637		
Date Assigned:	10/23/2015	Date of Injury:	12/28/2012
Decision Date:	12/08/2015	UR Denial Date:	10/01/2015
Priority:	Standard	Application Received:	10/21/2015

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: New York, Pennsylvania, Washington
 Certification(s)/Specialty: Internal Medicine, Geriatric Medicine

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 59 year old male who sustained an industrial injury on 12-28-2012. According to a progress report dated 07-28-2015, the injured worker reported pain in the lower back with radiation to both legs. Pain was associated with tingling and weakness in the legs. Pain was rated 9 on a scale of 0-10. Pain at its best was 7 and at its worst 10. Average pain over the last seven days was 9. He could walk one block before having to stop because of his pain. Over the past month, he avoided going to work socializing with friends, physical exercise, performing household chores, participating in recreation, driving and having sexual relations because of pain. Gait pattern was normal. There was tenderness to palpation over the bilateral lumbar paraspinal muscles. There was no sciatic notch tenderness and no gluteal spasm. There was positive straight leg raise test on the right in the seated and supine position to 50 degrees. Normal bulk and tone in all major muscle groups of the lower extremities was noted. Motor strength was 5 out of 5 throughout the bilateral lower extremities. The treatment plan included Alprazolam and Hydrocodone. According to an encounter report dated 09-09-2015, subjective and objective findings were note recorded. Assessment included lumbar radiculitis. Diagnoses included displacement of lumbar intervertebral disc without myelopathy. The treatment plan included Alprazolam and Hydrocodone. An authorization request dated 09-15-2015 was submitted for review. The requested services included Hydrocodone 10-325 mg #60 and Alprazolam 0.25 mg one orally at bedtime. On 10-01-2015, Utilization Review non-certified the request for Hydrocodone 10-325 mg #60 and Alprazolam 0.25 mg #30. Documentation shows use of Alprazolam dating back to 05-05-2015 and use of Hydrocodone dating back to 06-16-2015. Urine toxicology reports were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10/325mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids, specific drug list, Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: Per the guidelines, in opioid use, ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects is required. Satisfactory response to treatment may be reflected in decreased pain, increased level of function or improved quality of life. The MD visit fails to document any significant improvement in pain, functional status or a discussion of side effects specifically related to opioids to justify use per the guidelines. Additionally, the long-term efficacy of opioids for chronic back pain is unclear but appears limited. The request for hydrocodone is not medically necessary or substantiated in the records.

Alprazolam 0.25mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

Decision rationale: Per the guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. The MD visit does not document any significant improvement in pain or functional status or a discussion of side effects specifically related to valium to justify use. A more appropriate treatment for anxiety disorder is an antidepressant and tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. In this injured worker, the records do not document medical necessity. The request is not medically necessary.