

Case Number:	CM15-0026929		
Date Assigned:	02/19/2015	Date of Injury:	05/29/2013
Decision Date:	03/31/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/12/2015

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: TR, California, Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational 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 39 year old female who sustained an industrial injury on May 29, 2013. She has reported severe low back pain with radiation into the right buttock and down the lateral aspect of the right thigh with numbness and tingling in the left foot and leg. The diagnoses have included lumbar degenerative disc disease. Treatment to date has included diagnostic studies, physical therapy, medication and spinal cord stimulator implantation on 01/14/2015. On January 16, 2015, the injured worker complained of worsening low back pain with numbness in the left foot and leg. The pain was described as throbbing, aching, burning and sharp. Her pain is worse with standing, walking, bending and lifting. Pain is reportedly somewhat relieved with rest. Her daily activities are limited due to the pain. She has difficulty sleeping at night. On January 30, 2015 Utilization Review non-certified Zanaflex 4mg #120 and Percocet 10/325mg #180, noting the CA MTUS/ACOEM Guidelines. On February 12, 2015, the injured worker submitted an application for Independent Medical Review for review of Zanaflex 4mg #120 and Percocet 10/325mg #180.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4 mg, 120 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. However, in most cases, they seem no more effective than NSAIDs for treatment. There is also no additional benefit shown in combination with NSAIDs. With no objective evidence of pain and functional improvement on the medication and a request for continued and chronic treatment with no indication of plan for return to work, close follow up for functional improvement, etc., the quantity of medications currently requested cannot be considered medically necessary and appropriate.

Percocet 10/325 mg, 180 count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Section. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Opioids for Chronic Pain Section

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

Decision rationale: Chronic use of opioids is addressed thoroughly by the MTUS chronic pain guidelines and given the long history of pain and treatment in this patient since the initial date of injury (May 29, 2013), consideration of the MTUS Criteria for Use of Opioids in chronic pain is appropriate. On January 16, 2015, Utilization Review denied certification for Percocet 10/325mg #180, indicating prior utilization review had non-certified previous requests for Percocet, and stating that continued use at the same or higher dose without weaning is inappropriate. Documentation of pain and functional improvement are critical components, along with documentation of adverse effects. While the MTUS does not specifically detail a set visit frequency for re-evaluation, recommended duration between visits is 1 to 6 months. In this case, the patient clearly has concerns warranting close monitoring and treatment, to include close follow up regarding improvement in pain/function; consideration of additional expertise in pain management should be considered if there is no evidence of improvement in the long term. More detailed consideration of long-term treatment goals for pain (specifically aimed at decreased need for opioids), and further elaboration on dosing expectations with an approach to weaning in this case would be valuable. More detailed expectations should be outlined with the patient regarding the treatment plan and follow up scheduling working to decrease opioid dependency. Consideration of other pain treatment modalities and adjuvants is also recommended. Given the lacking evidence of functional improvement on opioids based on the provided records, the request for medications in the requested quantity without further evaluation is not considered in the opinion of this reviewer to be medically necessary and appropriate.