

Case Number:	CM15-0225393		
Date Assigned:	11/23/2015	Date of Injury:	09/12/2003
Decision Date:	12/31/2015	UR Denial Date:	10/22/2015
Priority:	Standard	Application Received:	11/17/2015

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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 65 year old female, who sustained an industrial injury on 09-12-2003. A review of the medical records indicates that the injured worker (IW) is undergoing treatment for osteopenia, lumbar degenerative disc disease, lumbar spinal stenosis, and osteoporosis. Medical records (05-04-2015 to 08-28-2015) indicate ongoing low back pain. Pain levels were 4-5 out of 10 on a visual analog scale (VAS). Records also indicate no changes in activity levels or level of functioning. Per the treating physician's progress report (PR), the IW has not returned to work. The physical exam, dated 08-28-2015, revealed tenderness in the lumbosacral musculature and axial spine over the X-stop scar, and pain with extension and rotation. Relevant treatments have included: X-stop, work restrictions, and medications (duragesic, Norco, and alprazolam for several months). A urine drug screening (08-28-2015) showed inconsistent results. The request for authorization (09-17-2015) shows that the following medications were requested: alprazolam 0.5mg #30 with 1 refill, hydrocodone-acetaminophen (Norco) 10-325mg #240, and duragesic patches 50mcg per hour #15. The original utilization review (10-22-2015) non-certified the request for alprazolam 0.5mg #30 with 1 refill, hydrocodone-acetaminophen (Norco) 10-325mg #240, and duragesic patches 50mcg per hour #15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Alprazolam 0.5mg #30 Q 8 hours with 1 refill: 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: According to the Chronic Pain Medical Treatment Guidelines, Benzodiazepines are not recommended for long-term use because its efficacy is unproven and there is a risk of addiction. Most guidelines limit its use to 4 weeks and its range of action includes: sedation, anxiolytic, anticonvulsant and muscle relaxant. In this case, the claimant had been on Alprazolam for several months. Long-term use is not indicated. Continued and chronic use of Alprazolam is not medically necessary.

Hydrocodone-Acetaminophen 10/325mg #240: Upheld

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

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

Decision rationale: Hydrocodone is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Hydrocodone for several months without indication of significant improvement in function. There was no mention of Tylenol, NSAID, Tricyclic or weaning failure. The continued use of Hydrocodone is not medically necessary.

Duragesic 50mcg/hr patch #15 Q 48 hours: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Duragesic (fentanyl transdermal system), Fentanyl.

Decision rationale: According to the guidelines, Fentanyl is an opioid analgesic with a potency eighty times that of morphine. Fentanyl is not recommended as a first-line therapy. The FDA-approved product labeling states that Fentanyl is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. In this case, the claimant had been on Hydrocodone along with Duragesic for several months. There was no indication that an oral long-acting medication could not be tolerated. Continued use of Fentanyl (Duragesic) is not medically necessary.