

Case Number:	CM15-0086269		
Date Assigned:	05/08/2015	Date of Injury:	06/28/2014
Decision Date:	06/15/2015	UR Denial Date:	04/24/2015
Priority:	Standard	Application Received:	05/05/2015

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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 52-year-old male, who sustained an industrial injury on 06/28/2014. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having status post right shoulder reconstruction and right rib fractures. Treatment to date has included use of transcutaneous electrical nerve stimulation unit, above listed procedure, medication regimen, and therapy. In a progress note dated 03/19/2015 the treating physician reports complaints of to the right shoulder pain, right rib pain, and low back pain. The documentation from this date noted that the pain was rated a 7 out of 10 to the right shoulder, a 5 out of 10 to the right rib, and a 6 out of 10 to the low back, but did not indicate if these levels were with or without the injured worker's medication regimen. The treating physician notes tenderness to the right shoulder with positive impingement signs, Jobe test, and apprehension test. The treating physician requested the medications of Hydrocodone 10mg with a quantity of 120 and Xanax 0.5mg with a quantity of 60 noting that these medications are part of the injured worker's current medication regimen. The medical records provided did not indicate the effectiveness of these medications with regards to functional improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for hydrocodone, California Pain Medical Treatment Guidelines state that hydrocodone is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested hydrocodone is not medically necessary.

Xanax 0.5mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 24 of 127.

Decision rationale: Regarding the request for Xanax (alprazolam), Chronic Pain Medical Treatment Guidelines state the 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. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant." Within the documentation available for review, there is no documentation identifying any objective functional improvement because of the use of the medication and no rationale provided for long-term use of the medication despite the CA MTUS recommendation against long-term use. Benzodiazepines should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In the absence of such documentation, the currently requested Xanax (alprazolam) is not medically necessary.