MAXIMUS Federal Services

Case Number:	CM14-0114682		
Date Assigned:	09/23/2014	Date of Injury:	05/06/2010
Decision Date:	10/29/2014	UR Denial Date:	07/07/2014
Priority:	Standard	Application Received:	07/22/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 40-year-old female who reported an injury on 05/06/2010. The mechanism of injury was not submitted for clinical review. The diagnoses include right sacroiliitis, thoracic discogenic pain, thoracic radiculitis, and myofascial pain syndrome, history of thoracic fusion, history of fusion, depression, anxiety, insomnia, and history of suicidal ideation. Previous treatments included TENS unit, physical therapy, medication, and surgery. Within the clinical note dated 06/17/2014 it was reported the injured worker complained of mid back pain. She reported the pain radiated to the lateral and anterior chest. The provider noted the injured worker had inflammation of her right sacroiliac joint likely related to the affected gait and a result to her mid back pain. The provider requested Norco, Lorzone, and OxyContin. However, a rationale was not submitted for clinical review. The request for authorization was submitted on 07/01/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 82-88, 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: The request for Norco 10/325mg #90 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The provider failed to document adequate and complete pain assessment within the documentation. The request submitted failed to provide the frequency of the medication. Additionally, the use a urine drug screen was not submitted for clinical review. Therefore, the request is not medically necessary.

Lorzone 750mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 67.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63, 64.

Decision rationale: The request for Lorzone 750mg #30 is not medically necessary. The California MTUS Guidelines recommend nonsedating muscle relaxants with caution as a second line option for short term treatment and acute exacerbation in patients with chronic low back pain. The guidelines do not recommend the use of the medication longer than 2 to 3 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.