

Case Number:	CM14-0134905		
Date Assigned:	08/27/2014	Date of Injury:	02/28/2009
Decision Date:	10/31/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	08/21/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in California. 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 57-year-old male who reported an injury on 02/28/2009. The mechanism of injury was not provided. The injured worker's diagnoses included status post ACDF at C5-6, facet arthropathy at C2-3, major depressive disorder, status post right carpal tunnel release, status post right shoulder arthroscopy, atrial fibrillation, and heart stent placement. The injured worker's past treatments included a home exercise program, medications and 8 sessions of chiropractic therapy. The injured worker's surgical history included a right shoulder surgery and cervical spine surgery. On 07/10/2014, the injured worker complained of ongoing neck and low back pain. He reported stabbing and aching neck pain with radiation of numbness to the bilateral upper extremities extending down to the fingertips. The injured worker rated his pain a 7-8/10 on the pain scale. He reported that his medication provided some pain relief. Upon physical examination, the injured worker was noted with decreased range of motion of the cervical and lumbar spine in all planes. He had increased pain with cervical extension. There was tenderness to palpation of cervical midline and paraspinals and lumbar paraspinals. The injured worker's medications included Percocet 10/325 mg, Zanaflex 4 mg, and Plavix. The request was for Percocet 10/325 mg and Zanaflex 4 mg. The rationale for the request was for pain and spasm. The Request for Authorization form was signed and submitted on 07/10/2014

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80.

Decision rationale: The request for Percocet 10/325mg #90 is not medically necessary. The California MTUS Guidelines may recommend ongoing opioid therapy for patients with ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The pain assessment should include: a quantified current pain; the least reported pain over the period since last assessment; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug related behaviors. The guidelines may recommend continuation of opioids if the patient has returned to work and if the patient has improved functioning and pain. The most recent urine drug test from 10/02/2013, was noted to reveal hydrocodone and hydromorphone to be present, which was consistent with his prescribed medications. The injured worker reported a pain level of 7/10 on the pain scale. The documentation did not provide sufficient evidence of the efficacy of the medication to included indications of an objective increase in function and decrease in pain. The injured worker reported the medications provide some pain relief, however, in the absence of documentation with sufficient evidence of a quantified pain evaluation to objectively indicate a decrease in pain and documented evidence of significant objective functional improvement, the request is not supported. Additionally, as the request is written, there was no frequency provided. Therefore, the request is not medically necessary

Zanaflex 4mg 330: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63, 66.

Decision rationale: The request for Zanaflex 4mg 330 is not medically necessary. The California MTUS Guidelines may recommend non-sedating muscle relaxants with caution as a secondary line option for short term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain cases, they show no benefit beyond NSAIDs and pain and overall improvement. Efficacy appears to diminish over time and prolonged use of some medications in this class may lead to dependence. Zanaflex is FDA approved for management of spasticity. Side effects include hepatotoxicity and liver function tests should be monitored at baseline, 1 month, 3 months, and 6 months. The injured worker reported that his medication provided some pain relief; however, the documentation did not

provide objective functional improvement with the use of the medication. The injured worker was documented to have been using the medication since at least 04/2014 with no documented evidence of sufficient efficacy. In the absence of documentation with sufficient evidence of the efficacy indicated by a significant objective functional improvement and decrease in pain, the request is not supported. Additionally, as the request was written, there was no frequency provided. Therefore, the request is not medically necessary