

Case Number:	CM14-0212310		
Date Assigned:	01/02/2015	Date of Injury:	05/13/2009
Decision Date:	02/28/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/18/2014

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. 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

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:

Injured worker is a male with date of injury 5/13/2009. Per interventional pain management follow up evaluation report dated 9/18/2014, the injured worker complains of constant severe low back pain, which radiates to the bilateral lower extremities, greater on the left side. He rates his pain at 8/10. He notes that his low back pain has decreased since his last visit. He denies having had any procedures done to alleviate his pain. He has taken his medication regularly and has tolerated them well. He states his medications are helping with his pain. On examination he has an antalgic gait on the left and walks with the assistance of a cane. He performed heel-toe walk on the right with difficulty, and was unable to perform on the left. There is facet tenderness to palpation at the L4 through S1. There is also exquisite tenderness to the pedicle screws. Sacroiliac tenderness, Fabere's/Patrick, sacroiliac thrust, and Yeoman's tests are positive bilaterally. Kemp's test is positive bilaterally. Seated and supine straight leg raise are positive bilaterally. Farfan test is positive bilaterally. Lumbar spine range of motion is reduced. There is decreased sensation along the L5 and S1 dermatomes on the left. Lower extremity strength is 5/5 on the right and 4/5 on the left. Deep tendon reflexes on the left are reduced compared to the right. Diagnoses include 1) status post lumbar fusion at the L5-S1 2) status post hardware removal 3) lumbar disc disease 4) lumbar radiculopathy 5) lumbar facet syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 7.5mg Qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine section, Muscle Relaxants (for pain) section Page(s): 41,42,63,64.

Decision rationale: Cyclobenzaprine is recommended by the MTUS Guidelines for short periods with acute exacerbations, but not for chronic or extended use. These guidelines report that the effect of cyclobenzaprine is greatest in the first four days of treatment. Cyclobenzaprine is associated with a number needed to treat of three at two weeks for symptoms improvement in low back pain and is associated with drowsiness and dizziness. This request is noted to be for a refill. There is no acute exacerbation noted in this chronic pain patient. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. Chronic use of cyclobenzaprine may cause dependence, and sudden discontinuation may result in withdrawal symptoms. Discontinuation should include a tapering dose to decrease withdrawal symptoms. This request however is not for a tapering dose. The request for Flexeril 7.5mg Qty 90 is determined to not be medically necessary.

Norco 10/325mg Qty 180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80, 91, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section, Weaning of Medications section Page(s): 74-95,124.

Decision rationale: The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. This injured worker has been injured for over 5 years. This request is noted to be for a refill of medication. The injured worker is reported to have less pain than in the previous follow up visit, and medications are reported to be helpful. There is no report of the significance in pain reduction with the use of Norco 10/325 mg, objective functional improvement, ability to return to work, or improvement in quality of life. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The claims administrator modified this request to

allow for weaning of opioid pain medications. The request for Norco 10/325mg Qty 180 is determined to not be medically necessary.

Xanax 1mg Qty 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Alprazolam (Xanax)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The MTUS Guidelines do not support the use of benzodiazepines for long term use, generally no longer than 4 weeks, and state that a more appropriate treatment would be an antidepressant. The request for Xanax 1 mg Qty 30 is determined to not be medically necessary.