

Case Number:	CM15-0116861		
Date Assigned:	06/25/2015	Date of Injury:	05/12/2009
Decision Date:	07/24/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	06/17/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 54-year-old male, who sustained an industrial injury on 5/12/2009. He reported injury to his back and left arm after jumping from a burning truck. The injured worker was diagnosed as having rule out bilateral lumbar facet mediated pain, failed back surgery syndrome, low back pain, right sacroiliac joint pain and piriformis syndrome, and hypogonadism secondary to chronic opiate use. Treatment to date has included lumbar fusion surgery in 2011, diagnostics, injections, psychotherapy, and medications. Currently (5/27/2015), the injured worker complains of pain in his low back, right buttock, and right knee. Pain was rated 6/10 and unchanged from his previous visit. Also noted was new onset pain to the L3 dermatome for about 3 weeks. An injection to the right sacroiliac joint on 3/02/2015 resulted in nearly 100% relief in that area, but he had a burning sensation in the right buttock. He was using a topical compound, only at night, and noted that it helped. Fentanyl patches were significantly more effective. He reported right leg weakness and was using a cane. He was able to do household chores, sleep, and other activities of daily living (with the use of medications and injections). He used Tizanidine at night for leg cramps. It was documented that he was self-paying for Fentanyl and Norco. The treatment plan included a request for bilateral lumbar medial branch blocks and refill of medications. His work status was "disabled." Psychological testing (12/2014) noted "moderate" depression and anxiety. Urine toxicology was not noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl 50mcg #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl Transdermal, Opioids, and Criteria for Use, Weaning of Medications Page(s): 76-82, 91, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (Fentanyl transdermal system) Page(s): 68.

Decision rationale: According to MTUS guidelines, "Duragesic (Fentanyl transdermal system). Not recommended as a first-line therapy. Duragesic is the trade name of a Fentanyl transdermal therapeutic system, which releases Fentanyl, a potent opioid, slowly through the skin. It is manufactured by [REDACTED] and marketed by [REDACTED] (both subsidiaries of [REDACTED]). The FDA-approved product labeling states that Duragesic 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 patient continued to have pain despite the use of opioids. There is no documentation of continuous monitoring of adverse reactions and of patient's compliance with his medication. In addition, there is no documentation that the patient developed tolerance to opioids or need continuous around the clock opioid administration. Therefore, the prescription of Fentanyl 50mcg # 10 is not medically necessary.

Hydrocodone/Acetaminophen 10-325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen, Opioids, and Criteria for Use, Weaning of Medications Page(s): 76-80, 91, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

Decision rationale: According to MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: "(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. 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 (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework." According to the patient's file, there is no objective documentation of pain and functional improvement to justify continuous use of Norco. Norco was used for longtime without documentation of functional improvement or evidence of return to work or improvement of activity of daily living. Therefore, the prescription of Norco 10/325mg #90 is not medically necessary.

Tizanidine 4mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63, 65, 66.

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

Decision rationale: According to MTUS guidelines, non-sedating muscle relaxants are recommended with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient in this case does not have clear evidence of spasm and the prolonged use of Tizanidine is not justified. Therefore, the request for Tizanidine 4mg #30 is not medically necessary.