

Case Number:	CM15-0177864		
Date Assigned:	09/18/2015	Date of Injury:	03/21/2002
Decision Date:	11/03/2015	UR Denial Date:	08/14/2015
Priority:	Standard	Application Received:	09/09/2015

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: Pennsylvania, Ohio, California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 female who sustained an industrial injury on 3-21-2002. A review of medical records indicates the injured worker is being treated for thoracic lumbosacral neuritis radiculitis, reflex sympathetic dystrophy up limb, lumbago, degenerative lumbosacral intervertebral disc, and lumbosacral spondylosis without myelopathy. Medical records dated 8-3-2015 note there was no significant changes in pain since 5-20-2015. However, does note leg pain was worse. Physical examination noted 8-3-2015 noted ongoing low back pain and severe bilateral leg pain. She had decreased range of motion due to spondylolisthesis and continues with left greater than right leg pain of severe neuropathic symptoms. Treatment has included medications (Hydroxyzine and Zanaflex since at least 3-2-2015). MRI of the lumbar spine dated 8-19-2013 revealed mild retrolisthesis of L3 on L4, Interval progression of discogenic endplates change at L3-4 and L5-S1 with inferior neural foraminal narrowing. No significant spinal canal raises the possibility of component arachnoiditis. Utilization review form dated 8-14-2015 non-certified Hydroxyzine 50mg # 60 and Zanaflex 4mg # 60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydroxyzine 50mg #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA Approved Labeling Information for Hydroxyzine.

Decision rationale: Hydroxyzine is an H1 anti-histamine with indications including allergies, itching, anxiety, or vomiting. The records do not discuss their or other indications for this request. The clinical rationale for this medication is no apparent; this request is not medically necessary.

Zanaflex 4mg #60 with 1 refill: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: MTUS generally discourages the use of muscle relaxants for chronic conditions. For this reason an initial physician review recommended non-certification of this medication. However with regard to Tizanidine, MTUS discusses and endorses multiple studies regarding its efficacy for low back pain and myofascial pain and recommends its use as a first line treatment in such chronic situations. Thus the current request is consistent with MTUS guidelines; the request is medically necessary.