

Case Number:	CM15-0044138		
Date Assigned:	04/14/2015	Date of Injury:	06/03/2011
Decision Date:	05/29/2015	UR Denial Date:	02/13/2015
Priority:	Standard	Application Received:	03/09/2015

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: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 31-year-old female, who sustained an industrial injury on 06/03/2011. The injured worker was diagnosed as having chronic pain, cervical radiculopathy, lumbar radiculopathy, medication related dyspepsia and rule out right sacroiliitis. Treatment to date has included physical therapy, oral medications including opioids, transdermal medications and home exercise program. The injured worker presented on 01/13/2015 for a follow up evaluation with complaints of neck and low back pain as well as ongoing occipital migraine headaches. The examination of the cervical spine revealed paraspinal muscle spasm at C4-7; spinal vertebral tenderness; moderately limited range of motion secondary to pain; significantly increased pain with flexion, extension, and rotation; and decreased sensation in the bilateral upper extremities. The examination of the lumbar spine also revealed bilateral paraspinal musculature spasm at L4-5, tenderness to palpation, moderately limited range of motion secondary to pain, decreased sensation along the L5 dermatome in the bilateral lower extremities, diminished motor strength in the L5-S1 distribution of the bilateral lower extremities, diminished deep tendon reflexes, and positive straight leg raising at 60 degrees bilaterally. Testing for sacroiliac joint dysfunction revealed a right sided positive faber Patrick test and right sided Gaenslen's maneuver. The treatment recommendations at that time included continuation of the home exercise program and the current medication regimen. There was no Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP (Norco) 10/325mg #90 (x3-6 months): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized the above medication since at least 08/2014. There is no documentation of objective functional improvement. There is no documentation of a written pain consent or agreement for the chronic use of an opioid. Recent urine toxicology reports documenting evidence of patient compliance and non-aberrant behavior were not provided. The request for continuous refills for 3 to 6 months would not be supported. There is also no frequency listed in the request. As such, the request is not medically necessary.

Tizanidine HCL 2mg #60 (x3-6 months): Upheld

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

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

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short term treatment of acute exacerbations. Efficacy appears to diminish over time and prolonged use may lead to dependence. In this case, the injured worker has continuously utilized the above medication since at least 10/2014. There is no documentation of objective functional improvement. The guidelines do not support long term use of muscle relaxants. The request for continuous refills for 3 to 6 months would not be supported. There is also no frequency listed in the request. As such, the request is not medically necessary.

Exalgo (x3-6 months): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=22e635cb-98c0-e419-6a71-62d7487a0a6c>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized the above medication since at least 08/2014. There is no documentation of objective functional improvement. There is no documentation of a written pain consent or agreement for the chronic use of an opioid. Recent urine toxicology reports documenting evidence of patient compliance and non-aberrant behavior were not provided. The request for continuous refills for 3 to 6 months would not be supported. There is also no strength, frequency, or quantity listed in the request. As such, the request is not medically necessary.

Fioricet 50-325-40mg #60 (x3-6 months): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://www.nlm.nih.gov/medlineplus/druginfo/meds/a601009.html#why>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

Decision rationale: California MTUS Guidelines do not recommend barbiturate containing analgesic agents for chronic pain. There is a risk of medication overuse as well as rebound headache. Therefore, the request for Fioricet would not be supported. Additionally, the request for ongoing refills for 3 to 6 months would not be supported. There is also no frequency listed in the request. As such, the request is not medically necessary.

Nalaxone 0.4mg/ml #2 EVZIO 1 ml prefilled syringes (x3-6 months): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://www.nlm.nih.gov/medlineplus/druginfo/meds/a612022.html>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75, 100. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Naloxone (Narcan^{1/2}).

Decision rationale: California MTUS Guidelines state opioid antagonists such as naloxone are most often used to reverse the effects of agonist and agonist antagonist derived opioids. Naloxone is also indicated for the reversal of opioid overdose. The Official Disability Guidelines state naloxone is recommended in hospital based and emergency department settings as currently indicated to address opioid overdose cases. In this case, there is no documentation of a complete history including questions about prior drug and alcohol use. There is no evidence that education has been provided to the injured worker. There is also no evidence of counseling about drug use or risk of overdose. The medical necessity for the requested medication has not been established in this case. Therefore, the request is not medically appropriate at this time.

Fentanyl Patch 12 mcg/hr #10 (x3-6 months): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44.

Decision rationale: California MTUS Guidelines state fentanyl transdermal system is not recommended as a first line therapy. It is indicated in the management of chronic pain in patients who require continuous opioid analgesic for pain that cannot be managed by other means. In this case, there is no evidence of a failure to respond to first line treatment. There is no documentation of a written consent or agreement for chronic use of an opioid. Recent urine toxicology reports documenting evidence of patient compliance and non-aberrant behavior were not provided. The injured worker has continuously utilized the above medication since 12/2014 without any evidence of objective functional improvement. The request for ongoing refills for 3 to 6 months would not be supported. There is also no frequency listed in the request. As such, the request is not medically necessary.

Retro Range of Motion Measurements: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: California MTUS/ACOEM Practice Guidelines state a number of functional assessment tools are available including Functional Capacity Examination when reassessing function and functional recovery. In this case, there was no documentation of the specific type of range of motion measurements completed. Range of motion testing should be considered part of a standard office visit. The medical necessity for the current request has not been established in this case. Therefore, the request is not medically appropriate at this time.

Bilateral L4-S1 lumbar transforaminal steroid infusion: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

Decision rationale: The California MTUS Guidelines recommend epidural steroid injection as an option for treatment of radicular pain. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, the injured worker has been previously treated with lumbar epidural steroid injections. There

was no documentation of significant functional improvement following the initial procedure. Given the above, an additional procedure would not be supported. As such, the request is not medically necessary.

Cervical Injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

Decision rationale: California MTUS/ACOEM Practice Guidelines state invasive techniques have no proven benefit in treating acute neck and upper back symptoms. The specific type of injection was not listed in the request. The medical necessity has not been established. As such, the request is not medically appropriate.