

Case Number:	CM15-0077660		
Date Assigned:	04/29/2015	Date of Injury:	10/19/1990
Decision Date:	05/28/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	04/23/2015

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: Maryland

Certification(s)/Specialty: Internal Medicine, Rheumatology

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 63 year old female, who sustained an industrial injury on 10/19/1990. Diagnoses have included chronic low back and leg pain, status post L4-5 and L5-S1 internal disc derangement, lumbar radiculopathy, lumbar degenerative disc disease, lumbar facet joint disease and depression/anxiety. Treatment to date has included H-wav machine and medications. According to the progress report dated 3/30/2015, the injured worker complained of constant low back pain. Average pain was rated 5-6/10 with medications. The pain radiated to the right leg. The injured worker ambulated with a cane. There was mild tenderness to palpation at the lumbar paraspinal muscles and along the facet joint line L1-S1, more on the right side. Authorization was requested for Duragesic patches, Hydrocodone/acetaminophen and Tizanidine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duragesic 25mcg/hr patch 72hr #10: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-85, 88-89.

Decision rationale: This 63 year old male has complained of low back pain since date of injury 10/19/90. He has been treated with H wave therapy, physical therapy and medications to include opioids since at least 12/2014. The current request is for Duragesic 25 mcg. No treating physician reports adequately assess the patient with respect to function, specific benefit, return to work, signs of abuse or treatment alternatives other than opioids. There is no evidence that the treating physician is prescribing opioids according to the MTUS section cited above which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opioid contract and documentation of failure of prior non-opioid therapy. On the basis of this lack of documentation and failure to adhere to the MTUS guidelines, Duragesic 25 mcg is not indicated as medically necessary.

Hydrocodone/Acetaminophen 325/5mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-85, 88-89.

Decision rationale: This 63 year old male has complained of low back pain since date of injury 10/19/90. He has been treated with H wave therapy, physical therapy and medications to include opioids since at least 12/2014. The current request is for Hydrocodone/Acetaminophen. No treating physician reports adequately assess the patient with respect to function, specific benefit, return to work, signs of abuse or treatment alternatives other than opioids. There is no evidence that the treating physician is prescribing opioids according to the MTUS section cited above which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opioid contract and documentation of failure of prior non-opioid therapy. On the basis of this lack of documentation and failure to adhere to the MTUS guidelines, Hydrocodone/Acetaminophen is not indicated as medically necessary.

Tizanidine 2mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 41.

Decision rationale: This 63 year old male has complained of low back pain since date of injury 10/19/90. He has been treated with H wave therapy, physical therapy and medications to include Tizanidine since at least 12/2014. The current request is for Tizanidine. Per the MTUS guidelines cited above, muscle relaxant agents (Tizanidine) are not recommended for chronic use and should not be used for a greater than 2-3 week duration. Additionally, they should not be

used with other agents. On the basis of these MTUS guidelines, Tizanidine is not indicated as medically necessary.