MAXIMUS Federal Services

Case Number:	CM15-0090229		
Date Assigned:	05/14/2015	Date of Injury:	06/03/2011
Decision Date:	07/03/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	05/11/2015

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, Hawaii
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 32 year old female, who sustained an industrial injury on June 3, 2011. She reported neck pain and low back pain. The injured worker was diagnosed as having chronic pain, cervical radiculopathy, lumbar radiculopathy, medication related dyspepsia, rule out right sacroiliitis and sleep disruptions. Treatment to date has included radiographic imaging, diagnostic studies. Currently, the injured worker complains of neck pain with associated bilateral upper extremity pain, numbness, tingling and migraine headaches and low back pain with associated lower extremity pain, weakness and tingling worse on the right than the left. She also noted difficulty sleeping and limitations in performing activities of daily living. The injured worker reported an industrial injury in 2001, resulting in the above noted pain. She was treated conservatively without complete resolution of the pain. Evaluation on February 20, 2015, revealed continued constant pain effecting her ability to be active without the use of medications. Evaluation on March 24, 2015, revealed continued pain as noted. She reported reduction in pain and an increase in the ability to perform activities of daily living with the use of medications. Medications were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Short-acting opioids, On-Going management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The patient presents with pain affecting the cervical and lumbar spine. The current request is for Norco 10/325mg #90. The treating physician states in the report dated 3/24/15 (14B), "The opioid analgesic effect has allowed this patient to increase/maintain activities of daily living and function. The prescribed medication has been well tolerated without significant adverse side effects." The treating physician also documents that the patient rates their pain as 4/10 with medication and 8/10 without medication. For chronic opiate use, the MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, the treating physician has documented that the patient has decreased pain, is able to perform ADLs, has not had any side effects to the medication, and has not demonstrated any aberrant behaviors. The current request is medically necessary.

Fentanyl 12mcg #10: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl, On-Going Management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The patient presents with pain affecting the cervical and lumbar spine. The current request is for Fentanyl 12mcg #10. The treating physician states in the report dated 3/24/15 (16b), "Fentanyl patch has been provided to this patient to manage intractable chronic pain. The pain cannot be managed by other means (e.g. NSAIDs)." The MTUS guidelines recommend Fentanyl transdermal (Duragesic) for management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. For chronic opiate use, the MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, the treating physician has documented that the patient has decreased pain, is able to perform ADLs, has not had any side effects to the medication, and has not demonstrated any aberrant behaviors. The current request is medically necessary.

Fioricet 50/350/40mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

Decision rationale: The patient presents with pain affecting the cervical and lumbar spine. The current request is for Fioricet 50/350/40mg #60. The treating physician states in the report dated 3/24/15, "Fioricet prescribed for headaches/pain." (14B) The MTUS guidelines state, "Not recommended for chronic pain. There is a risk of medication overuse as well as rebound headache." In this case, the treating physician has prescribed a medication the MTUS guidelines to not recommend. The current request is not medically necessary and the recommendation is for denial.

Tizanidine HCL 2mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs, Tizanidine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 60.

Decision rationale: The patient presents with pain affecting the cervical and lumbar spine. The current request is for Tizanidine HCL 2mg #60. The treating physician states in the report dated 3/24/15 (14B), "Muscle relaxant prescribed for occasional muscle spasm." The MTUS guidelines support Zanaflex for low back pain, myofascial pain and for fibromyalgia. In this case, the treating physician documents that the patient has been dealing with myofascial pain and low back pain and has decreased pain and has functional improvement in ADLs with medication usage. The current request is medically necessary and the recommendation is for authorization.