

Case Number:	CM13-0023216		
Date Assigned:	01/15/2014	Date of Injury:	10/05/2005
Decision Date:	08/13/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	09/11/2013

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. The expert reviewer is Board Certified in Anesthesiologist Pain Medicine and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 58-year-old male who reported an injury on 10/05/2005. The mechanism of injury was noted to be pushing a car on an assembly line. His prior treatments included chiropractic care, trigger point injections, epidural steroid injections, medial branch block, and medication. The injured worker's diagnoses are noted to be lumbar facet syndrome, lumbar radiculopathy, spasms of muscle, and mood disorder. The clinical evaluation on 06/26/2013, noted the injured worker with complaints of increased pain in his back radiating down both legs. On a scale of 1 to 10, the injured worker rated pain at 9. The injured worker indicated pain interferes with sleep. The physical examination noted limited range of motion in the lumbar spine with tenderness to palpation over the sacroiliac region. Muscle strength testing was limited by pain. On sensory examination, it is noted light touch sensation was decreased over the thigh of the left leg. Deep tendon reflexes were normal and equal on both sides. The treatment plan included medication refills and education; labs to evaluate liver, kidney, and testosterone levels; and encouraged regular home exercise program with stretching. The provider's rationale for the request was not provided within the documentation. A request for authorization for medical treatment was dated 08/06/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

TESTIM 1% (50MG) GEL, #28: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 110.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone replacement for hypogonadism (related to opioids) Page(s): 110-111.

Decision rationale: The request for TESTIM 1% (50 MG) GEL, #28 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines recommend testosterone replacement for hypogonadism in limited circumstances for patients taking high dose long-term opioids with documented low testosterone levels. The documentation provided for review does not indicate a diagnosis of hypogonadism. Although the treatment is for testing of testosterone, there is not a current testosterone lab level available with this evaluation. Long-term safety data of testosterone replacement is not available. In addition, the provider's request fails to indicate a frequency of application. As such, the request for Testim 1% (50 mg) gel, #28 is not medically necessary.

ZANAFLEX 2MG, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

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

Decision rationale: The request for Zanaflex 2 mg, #30 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines provide recommendations for muscle relaxants. Antispasticity/antispasmodic drugs are centrally acting adrenergic agonists that are FDA approved for management of spasticity; unlabeled use for low back pain. The injured worker's evaluation does not note spasticity. The injured worker's evaluation notes back pain; however, the injured worker stated that medications are less effective. The provider's request fails to indicate a frequency. Therefore, the request for Zanaflex 2 mg, #30 is not medically necessary.