

Case Number:	CM13-0038838		
Date Assigned:	12/18/2013	Date of Injury:	07/07/2009
Decision Date:	10/21/2014	UR Denial Date:	09/27/2013
Priority:	Standard	Application Received:	10/01/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 57-year-old male who reported an injury on 07/07/2009. The mechanism of injury was not stated. Current diagnoses include lumbar radiculopathy, status post lumbar surgery, and cervical spine strain. Previous conservative treatment includes TENS therapy and chiropractic treatment. Current medications include Ambien 10 mg, Vicodin, orphenadrine ER 100 mg, ketoprofen 75 mg, and omeprazole 20 mg. The injured worker was evaluated on 09/12/2013 with complaints of an exacerbation of lower back pain. Physical examination revealed paravertebral muscle tenderness in a cervical and lumbar spine with spasm. The injured worker also demonstrated a positive straight leg raise bilaterally and reduced sensation in the left S1 dermatomal distribution. Treatment recommendations included continuation of the current medication regimen and physical therapy 3 times per week for 4 weeks. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

ZOLPIDEM TARTARATE 10 PO #30.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker has continuously utilized this medication since 04/2013. Despite the ongoing use of this medication, the injured worker continues to report difficulty sleeping. There was also no frequency listed in the request. As such, the request is not medically appropriate at this time.

ORPHENADRINE ER 100 MG #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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. The injured worker has continuously utilized this medication since 04/2013. Despite the ongoing use of this medication, the injured worker continues to demonstrate palpable muscle spasm in the cervical and lumbar spine. There is also no frequency listed in the request. As such, the request is not medically appropriate.

OMEPRAZOLE DR. 20MG#30.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69..

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. There is also no frequency listed in the current request. As such, the request is not medically appropriate.

TWELVE (12) PHYSICAL THERAPY SESSIONS FOR THE BACK, RIGHT LEG:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99..

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. There was no documentation of a physical examination of the right lower extremity. Without evidence of a significant musculoskeletal or neurological deficit, physical medicine treatment cannot be determined as medically appropriate in this case. As the medical necessity has not been established, the request is not medically appropriate.