MAXIMUS Federal Services

Case Number:	CM13-0056997		
Date Assigned:	12/30/2013	Date of Injury:	01/19/2000
Decision Date:	05/06/2014	UR Denial Date:	10/24/2013
Priority:	Standard	Application Received:	11/25/2013

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 Family Practice and is licensed to practice in Texas. 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:

This is a 56-year-old female with a date of injury of 01/19/2000, and the mechanism of injury was due to cumulative trauma related to material handling and pushing and pulling equipment. The injury involved a strained neck, back and both upper extremities. An MRI of the lumbar spine on 11/29/2011 revealed degenerative disc disease at L3-4, L4-5 and L5-S1; a stable left paracentral 3 mm disc protrusion at L5-S1 with minimal displacement of the left S1 nerve root; stable, mild central canal stenosis at L3-4 from a diffuse disc bulge; moderate right neural foraminal narrowing at L4-5; and mild to moderate left neural foraminal narrowing at L3-4. On the physical exam on 10/29/2013, the injured worker presented with complaints of back and leg pain and difficulty walking. Reportedly, there has been no improvement from pain medications. On physical exam, there was moderate to severe tenderness on palpation of the mid-lumbar spine. Lower extremity strength revealed left dorsiflexion 4-/5, right hip flexion and knee extension 4-/5. There was diminished perception to light touch in the lateral shin and anterior foot of the left lower extremity. Gait was slow. Range of motion was restricted in flexion and extension. There was an antalgic gait; straight leg raise elicited pain in the low back at 30 degrees bilaterally. The diagnoses were lumbar disc syndrome, lumbar stenosis and dyspepsia, mild. The treatment plan was to request authorization for Dilaudid 4 mg 1 four times a day #120, Flexeril 7.5 mg one 3 times a day #90 and Protonix 20 mg 1 to 2 in the morning #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL PURCHASE OF DILUADID 4MG #120: 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 Opioids Page(s): 75.

Decision rationale: The CA MTUS Guidelines recommend Dilaudid as a short-acting method in controlling chronic pain as well as for intermittent or breakthrough pain. Ongoing monitoring for analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors is recommended. The request for an additional purchase of Dilaudid 4 mg #120 is non-certified. On 10/29/2013, the injured worker presented complaining of back and leg pain and difficulty walking as well as reporting no improvement from the use of the medications. The clinical information provided failed to provide the duration the patient has been taking this medication. The guidelines do support the use of Dilaudid and not for long-term use. Also, the clinical information failed to provide evidence of efficacy to include pain relief and improved function as well as side effects and aberrant behavior to support continuation of the medication. The request as submitted failed to provide the frequency at which the medication is prescribed to determine necessity. As such, the request is non-certified.

FLEXERIL 7.5MG #90: 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 Cyclobenzaprine (FlexerilÂ®) Page(s): 41-42.

Decision rationale: The CA MTUS Guidelines recommend Flexeril for a short course of therapy. Effectiveness is greatest in the first 4 days of treatment and addition of cyclobenzaprine to other agents is not recommended. Also, improvement of symptoms in low back pain is needed to be documented. The request for Flexeril 7.5 mg #90 is non-certified. The guidelines do not recommend the long-term use, and there was no evidence of functional improvement noted in the documentation submitted for review. Also, the request as submitted failed to include the frequency at which the medication is prescribed for to determine necessity. As such, the request is non-certified.

PROTONIX 20MG #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 NSAIDS, GI Symptoms & Cardiovascular Risk Page(s): 68.

Decision rationale: The CA MTUS Guidelines recommend Protonix for patients at intermediate risk for gastrointestinal events and no cardiovascular disease; also, long term PPI use (>1 year) has been shown to increase the risk of hip fracture. The request for Protonix 20 mg #60 is non-certified. There was no evidence in the documentation reviewed that indicated any current gastrointestinal events and objective findings indicating the use for a PPI. The request as submitted failed to frequency at which the medication was prescribed for to determine necessity. As such, the request is non-certified.