

Case Number:	CM13-0059884		
Date Assigned:	12/30/2013	Date of Injury:	03/04/2003
Decision Date:	05/23/2014	UR Denial Date:	11/05/2013
Priority:	Standard	Application Received:	12/02/2013

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 Anesthesiology, has a subspecialty in 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 55-year-old male who reported an injury on 03/04/2003. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to his low back and trunk. The injured worker was evaluated on 09/19/2013. It was documented that the injured worker had ongoing complaints of the cervical spine that included pain and weakness. It was noted that the injured worker had treatment history of epidural steroid injections, NSAIDs, ice, rest, and heat application with physical therapy. Physical findings included tenderness to palpation along the paralumbar musculature with decreased sensation and a positive straight leg raising test. Evaluation of the cervical spine documented a decreased range of motion secondary to pain with tenderness to palpation along the cervical musculature and trapezius musculature. It was noted that the injured worker had decreased sensation in the C5 dermatomes. The injured worker's diagnoses included cervical intervertebral disc disease, low back pain, lumbar radiculopathy, cervical radiculitis, cervical disc displacement, and lumbar disc displacement. A request was made for refill of tizanidine, Prilosec, Anaprox, Lunesta Proteolin, Restone, and Cartivisc.

IMR ISSUES, DECISIONS AND RATIONALES

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

TIZANIDINE TABLET 4MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex, generic available) Page(s): 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The requested tizanidine tablet 4 mg is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 06/2013. The California Medical Treatment Utilization Schedule does not recommend the extended use of this medication. Muscle relaxants are recommended for short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation does not support that the injured worker is experiencing an acute exacerbation of chronic pain. Therefore, continued use of this medication would not be supported. Additionally, the request as it is submitted does not contain and quantity or frequency of treatment. As such, the requested Tizanidine 4 mg is not medically necessary or appropriate.

PRILOSEC DELAYED RELEASE CAP 20 MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68.

Decision rationale: California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for injured workers who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's gastrointestinal system to support that they are at continued risk for development of gastrointestinal events related to medication usage. Therefore, continued use of this medication would not be supported. Additionally, the request as it is submitted did not provide a quantity or frequency of treatment. As such, the requested Prilosec delayed release capsules 20 mg is not medically necessary or appropriate.

ANAPROX 550 MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain and NSAIDs (Non-Steroidal Anti-Inflammatory Drugs) Page(s): 60, 68.

Decision rationale: California Medical Treatment Utilization Schedule does recommend the use of non-steroidal anti-inflammatory drugs in the management of chronic pain. However, the California Medical Treatment Utilization Schedule recommends that medications used in the management of chronic pain be supported by documentation of functional benefit and an assessment of pain relief. The clinical documentation submitted for review does not provide any evidence that the injured worker experiences pain relief or functional benefit from medication

usage. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 06/2013. Therefore, an adequate time to produce an appropriate effect has been provided. Additionally, the request as it is submitted did not provide a quantity or frequency of treatment. As such, the requested Anaprox 550 mg is not medically necessary or appropriate.

LUNESTRA TABLET 3 MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC, 5th Edition, 2007, Pain (Chronic), Insomnia Treatment.

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

Decision rationale: California Medical Treatment Utilization Schedule does not address insomnia treatments. Official Disability Guidelines do recommend the use of this medication for short durations of treatment for insomnia related to chronic pain. However, the clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 06/2013. Therefore, continued use would not be supported. Also, the clinical evaluation submitted for review did not provide an adequate assessment of the injured worker's sleep hygiene to support the need for pharmacological interventions. The request as it is submitted did not clearly identify a quantity or duration of treatment. As such, the requested Lunesta tablets 3 mg is not medically necessary or appropriate.

PORTEOLIN: Upheld

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

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

Decision rationale: The requested medication is a proprietary formulation of anti-inflammatory and immunomodulatory peptides, curcuminoids, piperine, and proteolytic enzymes. Official Disability Guidelines do not support the use of medical food unless a dietary need is specifically identified. Additionally, the request as it is submitted does not provide a frequency, dosage, or intended duration of treatment. As such, the requested Proteolin is not medically necessary or appropriate.

RESTONE: Upheld

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

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

Decision rationale: Restone is a combination of melatonin and L-tryptophan. Official Disability Guidelines recommended the use of this medication to assist with restoration of sleep patterns. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's sleep hygiene to support the need for pharmacological interventions. Additionally, the request as it is submitted does not clearly identify a dosage, frequency, or intended duration of treatment. As such, the request for Restone is not medically necessary or appropriate.

CARTIVISC: 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 Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: California Medical Treatment Utilization Schedule does recommend the use of glucosamine sulfate to assist with pain management related to osteoarthritis. However, the request as it is submitted does not clearly identify a dosage, frequency, or intended duration of treatment. Therefore, the appropriateness of the request cannot be determined. As such, the requested Cartivisc is not medically necessary or appropriate.

OXY IR 15MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: California Medical Treatment Utilization Schedule recommends the continued use of opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review fails to provide any evidence of increased functionality or pain relief as a result of medication usage. Additionally, there is no documentation that the injured worker is monitored for aberrant behavior. Therefore, continued use of this medication would not be supported. As such, the requested Oxycodone Immediate Release 15 mg #120 is not medically necessary or appropriate.