

Case Number:	CM13-0063746		
Date Assigned:	12/30/2013	Date of Injury:	12/11/2009
Decision Date:	06/10/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/10/2013

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 68-year-old male who reported an injury on 02/11/2009. The mechanism of injury was not specifically stated. Current diagnoses include lumbar degenerative disc disease with bilateral lower extremity radiculopathy, degenerative spondylolisthesis, lumbar facet syndrome, status post total hip replacement on 03/26/2009, umbilical hernia, and medication induced gastritis. The latest Physician's Progress Report submitted for this review is documented on 11/21/2013. The injured worker reported increasing lower back pain. Physical examination revealed an antalgic gait, mild leg length discrepancy on the right, tenderness to palpation, muscle rigidity, trigger points, limited lumbar range of motion, 5/5 motor strength, and decreased sensation in the L5-S1 distribution. Treatment recommendations at that time included continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

CIPROFLOXACIN HCL 500MG #30: 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) Infectious Disease Chapter, Ciprofloxacin (Cipro[®]).

Decision rationale: The Official Disability Guidelines state ciprofloxacin is recommended as a first line treatment for diabetic foot infections, osteomyelitis, chronic bronchitis, and other soft tissue infection. The injured worker does not maintain any of the above-mentioned diagnoses. There is also no frequency listed in the current request. As such, the request for Ciprofloxacin HCL 500mg #30 is not medically necessary.

PROMETHAZINE HCL 25 MG #5: 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) Chronic Pain Chapter, Antiemetic.

Decision rationale: The Official Disability Guidelines state antiemetics are not recommended for nausea and vomiting secondary to chronic opioid use. Promethazine is recommended as a sedative and an antiemetic in preoperative and postoperative situations. Therefore, the injured worker does not meet criteria for the requested medication. There is also no frequency listed in the current request. As such, the request for Promethazine HCL 25 mg #5 is not medically necessary.

HYDROCODONE-ACETAMINOPHEN 7.5 - 750MG #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 Page(s): 74-82.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized Hydrocodone since at least 03/2013. Despite ongoing use of this medication, the injured worker continues to report increasing lower back pain. There is no evidence of objective functional improvement. There is also no frequency listed in the current request. As such, the request for Hydrocodone-Acetaminophen 7.5 - 750mg #90 is not medically necessary.