MAXIMUS Federal Services

Case Number:	CM14-0107218		
Date Assigned:	08/01/2014	Date of Injury:	11/15/2003
Decision Date:	09/26/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/10/2014

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 Occupational 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 patient is a 47-year-old male who has submitted a claim for bilateral sacroiliitis, Piriformis syndrome, bilateral greater Trochanteric bursitis, and myofascial pain associated with an industrial injury date of 11/15/2013. Medical records from 10/17/2012 to 06/18/2014 were reviewed and showed that patient complained of hip and leg pain. Physical examination revealed bilateral lumbar paraspinous, sacral joint, Piriformis, and greater trochanters bursa tenderness, pain with lumbar extension and rotation bilaterally, positive FABER and hip distraction tests, negative SLR test, and intact MMT, DTRs, and sensation of lower extremities. Of note, there was documentation of unspecified gastrointestinal upset (10/17/2012). Recent medical records did not document GI disturbances. Treatment to date has included Fentanyl injection of left SI joint , Piriformis, and Trochanteric bursa (09/12/2012, 01/22/2013, and 03/24/2014), physical therapy, Lorazepam 1mg # 60 (prescribed since 10/17/2012), Ranitidine 150mg tab #60 (prescribed since 10/17/2012), and oral pain medications. Utilization review dated 07/01/2014 denied the request for Lorazepam 1mg #60 because benzodiazepines are not indicated for long-term use. Utilization review dated 07/01/2014 denied the request for ranitidine HCl 150mg #60 because the patient's clinical history does not warrant the use of the medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription for lorazepam 1 mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: According to page 24 of the MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Tolerance develops with long-term use. In this case, the patient was prescribed Lorazepam 1mg # 60 since 10/17/2012. However, there was no documentation of functional outcome with Lorazepam intake. Furthermore, the long-term use of Lorazepam is not in conjunction with guidelines recommendation concerning benzodiazepines. Therefore the request for Lorazepam 1mg # 60 is not medically necessary.

One prescription for ranitidine HCL 150 mg, #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guidelines Clearinghouse, ranitidine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Ranitidine).

Decision rationale: The MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, FDA was used instead. According to FDA, indications for ranitidine include short-term treatment and maintenance therapy of duodenal ulcer, short-term treatment and maintenance therapy for benign gastric ulcer, treatment of pathological hypersecretory conditions, treatment of GERD, and treatment and maintenance of erosive esophagitis. In this case, the patient was prescribed Ranitidine 150mg tab #60 since 10/17/2012. There was documentation of non-specific GI upset based on medical record dated 10/17/2012. However recent medical records do not indicate GI disturbances. Furthermore, there was no diagnosis of an underlying GI pathology such as duodenal or gastric ulcer, erosive esophagitis, hypersecretory conditions, or GERD to support Ranitidine treatment. There was no discussion as to why ranitidine treatment is needed. Therefore the request for Ranitidine HCl 150mg tab is not medically necessary.