

Case Number:	CM14-0108934		
Date Assigned:	08/01/2014	Date of Injury:	10/10/1994
Decision Date:	10/03/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/14/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 63 year-old female was reportedly injured on October 10, 1994. The mechanism of injury is not listed in these records reviewed. The most recent progress note, dated May 29, 2014, indicates that there are ongoing complaints of low back pain. An increase in activity level is noted. The physical examination demonstrated a 5'10", 230 pound individual with tenderness to palpation in the lower lumbar spine. A decrease in lumbar range of motion and cervical spine range of motion is reported. Diagnostic imaging studies were not reported. Previous treatment includes multiple lumbar surgeries to include fusion with instrumentation, injection therapy and pain management protocols. A request had been made for multiple medications and was not certified in the pre-authorization process on June 20, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Testosterone 200mg/ml 0.4cc/weekly, LLeR LK Syringe Needle, Quantity 12: 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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 110.

Decision rationale: As noted in the MTUS, when there is documented low testosterone levels were there is a hypogonadism (such as gynecomastia in males) this can be supported. There is a diagnosis of hypogonadism listed however there are no physical examination findings reported to objectify this assessment. Therefore, based on the incomplete clinical information presented this is not medically necessary.

Carisoprodol 350mg, Quantity 180 (30 day supply): 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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 29.

Decision rationale: The MTUS specifically recommends against the use of this medication and notes that is not indicated for long-term or chronic use. The clinical data presented does not establish any rationale for deviation from these guidelines. Therefore, when noting the parameters identified in the MTUS tempered by the physical examination findings there is insufficient clinical information presented support the medical necessity of this medication. As such, this request is not medically necessary.

Nuvigil 150mg, Quantity 30 (30 day supply):

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 updated September, 2014

Decision rationale: As outlined in the Official Disability Guidelines, (MTUS and ACOEM guidelines do not address) this medication is not recommended slowly to counteract sedation effects of narcotics. This medication is used to treat excessive sleepiness caused by narcolepsy or shift work sleep disorder. Furthermore, there is no indication of sleep apnea, shift work sleep disorder, narcolepsy which is the only clinical indications for the use of this medication. Therefore, this request is not medically necessary.

Avinza 120mg, Quantity 60 (30 day supply): 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 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 74, 75, 78, 93.

Decision rationale: The California MTUS Guidelines support long-acting opiates in the management of chronic pain when continuous around-the-clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no documentation of improvement in their pain level or increased in the overall functionality with the current treatment regimen. In the absence of subjective or objective clinical data, this request is not medically necessary.

Tizanidine 4mg, Quantity 60 (30 day supply): 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 8 C.C.R. 9792.20 - 9792.26 MTUS; (Effective July 18, 2009) Antispasticity/Antispasmodic Drug.

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha 2-adrenergic agonist that is FDA approved for management of spasticity. It is unlabeled for use in low back pain. Muscle relaxants are only indicated as 2nd line options for short-term treatment. It appears that this medication is being used on a chronic basis which is not supported by MTUS treatment guidelines. Therefore, this medication is not medically necessary based on the progress notes presented for review.