

Case Number:	CM14-0168349		
Date Assigned:	10/16/2014	Date of Injury:	08/07/2010
Decision Date:	11/25/2014	UR Denial Date:	10/08/2014
Priority:	Standard	Application Received:	10/13/2014

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 Neurology, 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 5/7/14 note indicates right lower extremity pain with medications of Tizanidine, Norco, Anaprox, and Protonix. There is normal strength and sensation in the lower extremities. 5/22/13 x-ray is reported to show hardware in good position. The insured is being considered for spinal cord stimulation. There is reported psychological clearance. The insured is reported to have failed medications, physical therapy, and surgery. The 6/13/14 note indicates pain in the back with radicular symptoms. There have been prior surgeries with persistent pain. Examination notes limited range of motion in the spine. 7/30/14 notes pain in the back with reduced sensation in the right L5 and S1 dermatomes. There were two leads sutured which were removed with no signs of infection. 9/5/14 notes indicates plan for permanent spinal cord stimulator placement. Plan of care was Levaquin, anaprox, and protonix. 9/9/14 indicates permanent spinal cord stimulator placement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Levaquin 750mg #10: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Infectious Diseases Procedure Summary

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: Sanford guide to antibiotic choice for pre-surgical procedure prophylaxis.

Decision rationale: Sanford guide for antibiotic treatment supports Levaquin is antibiotic of choice for urological procedures. The medical records indicate procedure of spinal cord stimulator placement which is not a urological procedure. There is no reported sensitivity to any antibiotics or medical records indicating reason for Levaquin. As such the medical records provided for review do not support Levaquin for pre-procedure.

Protonix 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's (non-steroidal anti-inflammatory).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 68.

Decision rationale: MTUS guidelines support use of H2 blocker for patients with demonstrated sensitivity to NSAIDS or documented h/o GERD or gastritis. The medical records do not indicate h/o GI related symptoms with NSAID use or h/o GERD or gastritis. As such the records do not support use of omeprazole for the insured congruent with MTUS guidelines.

Zanaflex 4mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Muscle relaxants

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines antispasticity drugs Page(s): 66.

Decision rationale: MTUS guidelines support zanaflex for treatment of spasticity or management of backpain. Use is based on presence of demonstrated muscle spasm and response to therapy for continued use. The medical records report pain and reduced range of motion despite treatment and as such does not support functional benefit from the treatment. As such the medical records do not support the continued use of zanaflex for the insured's condition.