MAXIMUS Federal Services

Case Number:	CM14-0033566		
Date Assigned:	06/27/2014	Date of Injury:	12/07/2005
Decision Date:	09/12/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/17/2014

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 injured worker is a 45 year-old male who was reportedly injured on December 7, 2005. The mechanism of injury was not listed in the records reviewed. The most recent progress note dated February 18, 2014, indicated that there were ongoing complaints of right hand and low back pains. It was also noted the pain level continued to be 7/10. There was also pain noted in the sacroiliac joints. The physical examination demonstrated the injured employee to be in moderate discomfort, with diffuse tenderness to palpation over the lumbosacral region, and with a decrease in lumbar spine range of motion. There was a reported disc sensory loss in the right upper extremity and the right lower extremity. Diagnostic imaging studies were not presented. Previous treatment included lumbar fusion surgery, postoperative rehabilitation, multiple medications and pain management interventions. A request was made for multiple medications and was not certified in the pre-authorization process on February 25, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Elavil 25mg #90 with 3 refills: 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13, 15.

Decision rationale: It is noted that there is a dysesthesia in the upper and lower extremities. Also noted, is the disc or lumbar fusion and the post syndrome. This medication has been attempted to treat the pain for a number of months. A prior reviewer allowed for continuation of medication and a reduced amount, as there was no noted efficacy. When noting the current physical examination compared to previous assessments, there is no documented efficacy or utility relative to the use of this medication. No decrease in pain complaints and still noted as 7/10. Therefore, when noting the parameters outlined in the California Medical Treatment Utilization Schedule and by the physical examination findings, this medication is not medically necessary.

Gabapentin 900mg #90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20, 49.

Decision rationale: It is noted that this individual continues to have dysesthesias in the upper and lower extremities. However, while this medication is supported to treat such neuropathic lesions, there is no noted efficacy demonstrated in the progress notes reviewed. There are continued complaints of pain with no improvement in functionality or decrease in symptomatology. Therefore, based on the clinical information presented, this is not medically necessary.

Pepcid 40mg #30 with 3 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.webmd.com/drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 70.

Decision rationale: As outlined in the California Medical Treatment Utilization Schedule, this medication is recommended to treat the sequelae of esophageal reflux disease and other irritant situations. The progress notes did not indicate any gastric distress or other complaints that would warrant a use of this medication. Therefore, when taking into account the lack of complaints, aptly no findings on physical examination to support there are any gastric disturbances and by the parameters noted in the California Medical Treatment Utilization Schedule, this is not medically necessary.

Zanaflex 4mg #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63, 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha 2-adrenergic agonist that is Food and Drug Administration 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 California Medical Treatment Utilization Schedule treatment guidelines. Therefore, this medication is not noting that there is no spasticity, and this medication is not medically necessary.

Oxycodone 15mg #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74, 78, 93.

Decision rationale: As outlined in the California Medical Treatment Utilization Schedule, these are short-acting opiates for the short-term management of moderate to severe breakthrough pain. However, there needs to be objectification of the functional utility or efficacy of this preparation. The pain complaints continued to be 7/10. There was no increase in functionality, no discussion of return to work and the overall clinical situation has been approved. As such, there is no clinical data presented to demonstrate this medication is achieving its intended effect and therefore is not medically necessary.