

Case Number:	CM14-0037944		
Date Assigned:	06/25/2014	Date of Injury:	12/30/2006
Decision Date:	08/14/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	03/28/2014

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 56 year-old individual who was reportedly injured on December 30, 2006. The mechanism of injury is not listed in these records reviewed. The most recent progress note dated January 3, 2014, indicates that there are ongoing complaints of neck pain rated as 9/10. The physical examination demonstrated a slow antalgic gait pattern, a single point cane, tenderness to palpation of the paravertebral musculature the lumbar region the spine associated muscle spasm and a decreased range of motion. The sensory exam noted a decreased sensation in the L4-L5 dermatome. Diagnostic imaging studies reportedly noted minimal disc disease and the tender changes. Electrodiagnostic studies were completed and were reported to be a normal study. Previous treatment includes multiple medications, physical therapy and pain management. A request was made for acupuncture and multiple medications and was not certified in the pre-authorization process on March 14, 2014. 6686

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture to Lumbar Spine, 4 Visits: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

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

Decision rationale: When noting the date of injury, the injury sustained, the treatment rendered, the response to the treatment rendered, the severity of pain complaints tempered by the electrodiagnostic findings and minimal changes on imaging studies there is little indication of any potential success with this intervention. Furthermore, as outlined in the California Medical Treatment Utilization Schedule, acupuncture is to be used when medicine is reduced or not tolerated. There is no indications that the medications are not tolerated. If anything, excessive medications are being employed. Therefore, the medical necessity for such an intervention has not been established in the progress notes presented for review.

Hydrocodone 10/325 #90, 1 by mouth 3 times a day: 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.

Decision rationale: When considering the injury sustained, the date of injury, the failure to improve and that the pain complaints are noted to be 9/10 when there are minimal changes noted on plain films. There are no electrodiagnostic findings and the physical examination did not reveal any substantive changes. There is no clinical indication that this medication has demonstrated any efficacy or utility. Furthermore, when noting that the California Medical Treatment Utilization Schedule establishes that this medication is for the short-term management of moderate to severe breakthrough pain, and this is not the clinical situation. There is no medical necessity established for this preparation.

Tizanidine 4mg #60, 1 tablet by mouth twice a daily: 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 Anti-Spasticity/Anti-spasmodic drugs Page(s): 66.

Decision rationale: Tizanidine is a centrally acting alpha2-adrenergic agonist that is Food and Drug Administration approved for management of spasticity. There are noted muscle spasm in the physical examination but there is no spasticity objectified. This medication 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 against the guideline recommendations. As such, the medical necessity for this preparation is not been established.

Omeprazole 30mg #30, 1 tablet by mouth 1 time daily: Upheld

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

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

Decision rationale: This medication is a proton pump inhibitor useful for the treatment of gastroesophageal reflux disease (GERD) and is considered a gastric protectant for individuals utilizing non-steroidal anti-inflammatory medications. It is noted that the medication Naprosyn has been prescribed, however there is no gastrointestinal distress issues outlined. There are numerous proton pump inhibitors available over the counter without a prescription. Gastritis has not been documented as a diagnosis for this injured worker. Therefore, the use of this medication is not medically necessary at this time.

Vitamin K 2000 unit #90, 3 tablets by mouth one time daily: 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 Pain Chapter Vitamin K.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chronic pain chapter, electronically cited.

Decision rationale: As noted in the American College of Occupational and Environmental Medicine guidelines, there is a specific recommendation against the use of dietary supplements for the treatment of chronic pain. There is no evidence to show any meaningful benefit or improvement and functional outcomes. Furthermore, the progress notes presented for review do not outline why vitamin K is indicated in this situation. As such, the medical necessity is not been established.