

Case Number:	CM14-0038307		
Date Assigned:	07/30/2014	Date of Injury:	02/23/1999
Decision Date:	09/09/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/01/2014

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 50-year-old male who was reportedly injured on February 23, 1999. The mechanism of injury was not listed in these records reviewed. The most recent progress note dated March 3, 2014, indicated that there were ongoing complaints of low back pain. The physical examination demonstrated a 5'8", 173 pound individual who appeared to be ill, and no other specific musculoskeletal findings were reported. Diagnostic imaging studies were not reported for review. Previous treatment included thoracic spine surgery, multiple trigger point injections, multiple medications, topical preparations and pain management interventions. A request was made for multiple medications and was not certified in the pre-authorization process on March 21, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective review Tramadol HCL (DOS 5/2/13): 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 (Effective July 18, 2009) Page(s): 82, 113.

Decision rationale: Considering the date of injury, noting the current complaints and the lack of any clinical indication that there is any efficacy or utility with the use of a 2nd line synthetic opioid analgesic, there is no clinical indication that this medication has any efficacy, utility or any additional medical necessity. There were complaints of pain in this 15-year-old injury; however, the medication profile as outlined does not appear to be ameliorating the symptomatology, increasing functionality or otherwise approved the overall clinical situation. As such, this medication is not medically necessary.

Retrospective Review Tizanidine HCL (DOS 5/2/13): 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: This medication is noted to be treatment for management of spasticity. There was no spinal cord injury or notation that there was spasticity identified in this clinical situation. Therefore, when taking note of the clinical information presented in the most recent progress note and by the parameters outlined in the California Medical Treatment Utilization Schedule, the medical necessity for this medication has not been established.

Retrospective Review Gabapentin (DOS 5/01/13): 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 (Effective July 18, 2009) Page(s): 16-20, 49.

Decision rationale: This medication is indicated for the treatment of a neuropathic pain lesion. There was no objective occasion of a neuropathic pain lesion. In fact, the only pathology noted, was a nociceptive finding of facet joint arthritis. Therefore, the clinical indication for this medication and the subsequent medical necessity has not been established.

Retrospective Review Celebrex (DOS 5/01/13): 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 (Effective July 18, 2009) Page(s): 30.

Decision rationale: This medication, a COX-2 inhibitor, is indicated for patients who have gastrointestinal issues. The progress notes listed did not outline that there were any gastritis, gastro esophageal reflux disease, or any other parameter whereby this type of medication be

warranted. Furthermore, there were no complaints or any gastric issues thereby eliminating the need for this medication in the long-term. As such, this is not medically necessary.

Retrospective review Skelaxin (DOS 5/1/13): Upheld

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 July 2014.

Decision rationale: As outlined in the Official Disability Guidelines, this medication can be used with caution as a 2nd line option for acute low back pain. If used in a chronic situation, this is for short-term relief only. When noting the date of injury, the current complaints, and the other medications prescribed, there is no noted efficacy with the utilization of this preparation. Therefore, given that there is no recommended clinical indication for this preparation and by the lack of any responses to medication noted in the physical examination, the medical necessity for the ongoing use of this preparation has not been established.

Retrospective review Treximet (DOS 5/1/13): Upheld

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 July, 2014.

Decision rationale: This is a medication (sumatriptan) combined with a non-steroidal (Naprosyn). The 1st point to make is that there are no noted migraine headaches objectified in the progress notes. The 2nd point is that this individual has been treated with a non-steroidal (Celebrex) and the 2nd non-steroidal is not clinically indicated. Thirdly, there is no clinical indication of any efficacy or utility in terms of decreased symptomatology or increase in functionality. Therefore, when noting the parameters outlined in the Official Disability Guidelines, there simply is no medical necessity established for continued use of this preparation.

Retrospective review Cymbalta (DOS 5/1/13): 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 (Effective July 18, 2009) Page(s): 122.

Decision rationale: As noted in the California Medical Treatment Utilization Schedule,, this is a tricyclic antidepressant. This is considered a first-line agent, unless it is ineffective or poorly tolerated. Progress notes indicate ongoing pain complaints with no relief in sight. Therefore, the objective parameters note that this is not effective in treating chronic low back pain. As such, the medical necessity for continuing this ineffective preparation is not outlined.