

Case Number:	CM14-0038804		
Date Assigned:	07/30/2014	Date of Injury:	05/01/2007
Decision Date:	08/29/2014	UR Denial Date:	03/27/2014
Priority:	Standard	Application Received:	04/02/2014

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 47 year-old female was reportedly injured on 5/1/2007. The mechanism of injury is noted as a pulling/lifting injury. The most recent progress note, dated 3/11/2014, indicates that there are ongoing complaints of chronic low back pain. The physical examination demonstrated lumbar spine: limited range of motion with pain, positive muscle spasms noted in the lumbar paraspinal muscles, antalgic gait using a cane. Sensory is decreased to light touch on the right S1 more so than L5, and L4 dermatome. Strength is 4/5 in the right ankle. Tenderness to the lumbar facet joints bilaterally in the right posterior superior iliac spine. Positive Patrick's test on the right. No recent diagnostic studies were available for review. Previous treatment includes previous surgeries, physical therapy, and medications. A request was made for lumbar corset, omeprazole 20 mg, Zanaflex 4 mg, Clonazepam 0.5 mg, and was denied in the pre-authorization process on 3/27/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar corset: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: ACOEM treatment guidelines do not support the use of a lumbar sacral orthosis (LSO) or other lumbar support devices for the treatment or prevention of low back pain except in cases of specific treatment of spondylolisthesis, documented instability, or postoperative treatment. The claimant is currently not in an acute postoperative setting and there is no documentation of instability or spondylolisthesis with flexion or extension plain radiographs of the lumbar spine. As such, the request is not medically necessary and appropriate.

Omeprazole 20 mg QD: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & cardiovascular risk Page(s): 98-69.

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): 68.

Decision rationale: Prilosec (Omeprazole) 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. An unspecified gastrointestinal (GI) disorder has not been documented as a diagnosis for this claimant. Therefore, the request is not medically necessary and appropriate.

Tizanidine 4 mg QHS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Spasticity/Anti-spasmodic drugs Page(s): 66.

Decision rationale: Zanaflex (Tizanidine) - Tizanidine is a centrally acting alpha2-adrenergic agonist that is Food and Drug Administration (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 against the guideline recommendations. Therefore, The request is not medically necessary and appropriate.

Clonazepam 0.5 mg Q HS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: MTUS guidelines do not support benzodiazepines (Clonazepam) for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most

guidelines limit use to four weeks. As such, this request is not medically necessary and appropriate.