

Case Number:	CM14-0080174		
Date Assigned:	07/18/2014	Date of Injury:	09/06/2012
Decision Date:	09/25/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/31/2014

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 45 year-old individual was reportedly injured on 9/6/2012. The mechanism of injury is noted as a lifting injury. The most recent progress note, dated 3/11/2014. Records indicate that there are ongoing complaints of low back pain, and bilateral upper extremity pain. The physical examination demonstrated bilateral upper extremities: positive tenderness to palpation over the distal aspect of the formed flexor and extensor muscle groups and tendons right more than left. Positive Tinnel's and Phalen are on the right wrist. Right index and thumb positive for decreased sensation. Positive Finkelstein's bilaterally. Thoracolumbar spine: positive tenderness to palpation over the thoracic paravertebral musculature with slight muscle guarding and spasm noted. Positive tenderness to palpation over the lumbar paravertebral musculature with muscle guarding and spasm noted as well. Straight leg raise test in both seated in supine positions on the left caused increased left-sided lower back pain with radiating symptoms into the left lower leg. Straight leg raise on the right caused increased left-sided low back pain. Thoracic and lumbar spine range of motion is performed with pain. Diagnostic imaging studies include x-rays of the lumbar spine from 3/11/2014 which reveal slight anterior spurring at L2-3 with evidence of mild spondylosis at this level. Previous treatment includes medications, and conservative treatment. A request had been made for physical therapy of the lumbar spine #8 visits, Motrin 800 mg #90, Zanaflex 4 mg #60, Remeron 15 mg #30, Prevacid 30 mg #30, and was not certified in the pre-authorization process on 4/30/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy x 8 visits, Lumbar: Upheld

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

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): 98, 99 of 127.

Decision rationale: MTUS guidelines support the use of physical therapy for the management of chronic pain specifically myalgia and radiculitis; and recommend a maximum of 10 visits. The claimant has chronic complaints of low back pain and review of the available medical records, fails to demonstrate an improvement in pain or function from previous physical therapy sessions, and in the absence of clinical documentation to support additional visits, this request is not considered medically necessary.

Motrin 800 mg #90: Upheld

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

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): 22 of 127.

Decision rationale: Ibuprofen is a nonselective, non-steroidal anti-inflammatory medication which has some indication for chronic low back pain. When noting the claimant's diagnosis and signs/symptoms, there is a clinical indication for the use of this medication as noted in the applicable guidelines. However, it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. There was no documentation of benefits of improvement in function or decrease in pain from the use of this medication, therefore it is deemed not medically necessary at this time.

Zanaflex 4 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS; (Effective July 18, 2009) Antispasticity/Antispasmodic Drugs: Page 66 of 127 Page(s): 66 of 127.

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha 2-adrenergic agonist that is 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 not supported by MTUS treatment guidelines. Therefore, this medication is deemed not medically necessary.

Remeron 15 mg #30: Upheld

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

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): 122 of 127.

Decision rationale: Remeron (Mirtazapine) is a tetracyclic anti-depressant used in the treatment of Major Depressive Disorder and other mood disorders. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. After review the medical documentation provided there was insufficient documentation concerning any physical exam findings or diagnosis associated with a mental health condition (depression). Therefore this request is deemed not medically necessary.

Prevacid 30 mg #30: Upheld

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

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): 68-69 of 127.

Decision rationale: MTUS guidelines support the use of proton pump inhibitors (PPI) in patients taking non-steroidal anti-inflammatory medications with documented gastroesophageal distress symptoms and/or significant risk factors. Review of the available medical records, state the injured worker did complain of gastritis, abdominal pain and heartburn which could possibly be associated with NSAID use. Because the request for continued use of NSAID has not been approved at this time, the request for this medication is deemed not medically necessary.