

Case Number:	CM14-0085656		
Date Assigned:	08/29/2014	Date of Injury:	05/29/2007
Decision Date:	10/08/2014	UR Denial Date:	05/19/2014
Priority:	Standard	Application Received:	06/09/2014

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 & 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 May 29, 2007 to the left leg and back as a result of her work duties. The most recent progress note, dated April 28, 2014, indicates that there are ongoing complaints of low back pain. However, it is noted that a sixty percent reduction of low back pain was noted with a bilateral sacroiliac joint block. The physical examination demonstrated a normotensive individual with a normal gait pattern, tenderness to palpation of lumbar spine, and Patrick's test is negative. Diagnostic imaging studies objectified multiple level ordinary disease of life degenerative changes and degenerative disc disease. Previous treatment includes multiple medications, conservative care, physical therapy, injection therapies and other pain management interventions. A request was made for multiple medications and was not certified in the preauthorization process on May 19, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, 3 x a day as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80-81, 91, 92 of 97.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91.

Decision rationale: Norco (Hydrocodone/Acetaminophen) is a short acting opiate indicated for the management in controlling moderate to severe pain. This medication is often used for intermittent or breakthrough pain. The California Medical Treatment Utilization Schedule (MTUS) guidelines support short acting opiates at the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain; however, there is no objective clinical documentation of improvement in their pain level, or increase in overall functionality with the current regimen. As such, this request for Norco is not medically necessary.

Tizanidine 4mg, 1 twice a day as needed: Upheld

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

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 (FDA) approved for management of spasticity. It is unlabeled for use in low back pain. Additionally, there is insufficient physical examination findings reported to support this request. Muscle relaxants are only indicated as second line options for short term treatment. It appears that this medication is being used on a chronic basis which is not supported by Medical Treatment Utilization Schedule (MTUS) treatment guidelines. Therefore, this medication is not medically necessary.

Prilosec 20mg 1 daily, # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitor Page(s): 68 of 127.

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

Decision rationale: This is a protein pump inhibitor useful for the treatment of gastroesophageal reflux disease and can be considered as a gastric protectorate for individuals utilizing nonsteroidal anti-inflammatory medications. However, the progress notes presented for review do not offer any complaints of gastrointestinal distress. Therefore, when noting the date of injury, the length of time these medications been employed, lack of any specific subjective complaints there is no clinical indication presented for the continued use of this medication. Therefore the request is not medically necessary.

Urine Toxicology Screen: 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 Criteria for the Use of Opioids Page(s): 78.

Decision rationale: As outlined in the Medical Treatment Utilization Schedule (MTUS), this is an option for chronic opioid use. However, there needs to be a clinical indication for such a study that would include either indicator of drug abuse, drug diversion, illicit drug use or some other parameter that would support the need for this intervention. Therefore, based on the clinical information presented for review there is no data to suggest a medical necessity for this assessment. Therefore the request is not medically necessary.

FluriPlex and TGICE, prn: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 110-112 and 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113.

Decision rationale: As outlined in the Medical Treatment Utilization Schedule (MTUS), these topical medications are largely experimental with few randomized controlled trials to demonstrate the efficacy or safety. Furthermore, there is no clear clinical indication for the use of topical muscle relaxants. Furthermore, topical nonsteroidal's (Flurbiprofen) is only indicated for short term an acute treatment. As such, there is insufficient clinical information presented to support the continued need or medical necessity of this topical preparation. Therefore the request is not medically necessary.

Sacroiliac Joint Belt: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298 and 301.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) hip chapter updated March, 2014

Decision rationale: The records reflect that there was a significant response to prior sequelae joint injection. As outlined in the Official Disability Guidelines (ODG) such a belt is recommended as an option in the conservative treatment of sick joint dysfunction. Therefore, based on the clinical information presented for review tempered by the parameters noted in the ODG the medical necessity of this device is supported. The request is medically necessary.