

Case Number:	CM14-0205270		
Date Assigned:	12/17/2014	Date of Injury:	12/11/2012
Decision Date:	02/04/2015	UR Denial Date:	11/08/2014
Priority:	Standard	Application Received:	12/08/2014

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 Internal Medicine, and is licensed to practice in New York. 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 claimant is a 50-years old male who sustained an industrial injury on 12/11/2012. The mechanism of injury was not provided for review. His diagnosis is low back pain secondary to lumbar disc disease. He continues to complain of low back pain which radiates down both legs causing weakness and numbness. Physical examination reveals upright posture and a non-antalgic gait. The flexion was 30/90 degrees, extension was 10/25 degrees, and right and left lateral flexion was 15/25 degrees with positive toe walk and positive heel walk. There was positive paraspinal tenderness to percussion. Treatment has included medical therapy. The treating provider has requested Omeprazole 20mg, Tizanidine 4mg #60, and Topical Biofreeze 16 oz.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines California MTUS 2009 Page(s): 68.

Decision rationale: Per California MTUS 2009 proton pump inhibitors are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any symptoms or GI risk factors. GI risk factors include: age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants or high dose/multiple NSAID. The claimant has no documented GI issues. Based on the available information provided for review, the medical necessity for Omeprazole has not been established. The requested medication is not medically necessary.

Tizanidine 4mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63, 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines California MTUS 2009 Page(s): 66.

Decision rationale: Tizanidine (Zanaflex) is a centrally acting alpha-2-adrenergic agent FDA approved for the treatment of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and as adjunct treatment for the treatment of fibromyalgia. Per California MTUS Guidelines muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. The claimant has no reported lumbar spasm on exam . Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Topical biofreeze 16 oz: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: There is no documentation provided necessitating use of the requested topical medication. Per California MTUS Guidelines topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, gamma agonists, prostanooids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The product, Biofreeze is recommended as an optional form of cryotherapy for acute pain. The claimant's date of injury occurred in 12/2012. There is no documentation of

intolerance to other previous cryotherapy treatments. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.