

Case Number:	CM15-0004380		
Date Assigned:	01/26/2015	Date of Injury:	01/28/2014
Decision Date:	03/23/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/08/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 33-year-old male who reported an injury on 01/28/2014. The mechanism of injury was a slip and fall. The diagnostic studies included MRIs and CT scan. The injured worker underwent a left shoulder surgery for decompression, debridement, and left rotator cuff repair on 07/12/2014. The injured worker's medications as of 07/2014 include naproxen 500 mg every 12 hours, tizanidine 4 mg at bedtime, and Prilosec 20 mg by mouth at bedtime. Other therapies included physical therapy. Documentation from 09/11/2014 revealed the injured worker had left hip and back pain. The pain was noted to be radiating down to his left lower extremity. The physical examination revealed an antalgic gait and ambulation with a cane. The injured worker had an area of severe tenderness and spasm bilaterally over the lumbar lower area, left more than right at L1 through the sacrum. The injured worker had decreased range of motion and decreased sensation at L5-S1 on the left. The injured worker had a straight leg raise test that was positive on the left. The fabere test and piriformis stretch test were positive on the left. The treatment plan included a left transforaminal epidural steroid injection, physical therapy for the lumbar spine, x-ray of the left hip, TENS unit, and utilized the medications including Norco for a maximum of 3 times per day, anti-inflammatory, ibuprofen with omeprazole and muscle relaxant, and adding gabapentin 300 mg at night to address the injured worker's recent radicular pain. The diagnoses included cervical radiculopathy and myelopathy, lumbosacral radiculopathy, lumbosacral degenerative disc disease and nerve impingement, as well as hip strain and bilateral possible degenerative joint disease, and lumbosacral, thoracic, and cervical spine strain. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine HCL 7.5 MG #30 with 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for short term treatment of acute low back pain. Their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documentation of objective functional improvement and there was a lack of documentation indicating a necessity for 2 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for cyclobenzaprine hydrochloride 7.5 mg #30 with 2 refills is not medically necessary.

Diclofenac 100 MG #30 with 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDs are recommended for short term symptomatic relief of low back pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and an objective decrease in pain. There was a lack of documentation indicating a necessity for 2 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for diclofenac 100 mg #30 is not medically necessary.

Neurontin 300 MG #60 with 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend antiepilepsy medications as a first line medication for the treatment of neuropathic pain. The clinical documentation submitted for review indicated the physician was adding Neurontin for neuropathic pain. The injured worker was noted to have neuropathic pain. There was a lack of documentation indicating with the addition of the medication there would be a necessity for 2 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Neurontin 300 mg #60 with 2 refills is not medically necessary.

Omeprazole 20 MG #60 with 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend that injured workers be assessed for risk for gastrointestinal events. If they are found to be at intermediate or high risk for gastrointestinal events, proton pump inhibitors are recommended. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. The efficacy of the requested medication was not provided. The documentation failed to indicate a necessity for 2 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for omeprazole 20 mg #60 with 2 refills is not medically necessary.