

Case Number:	CM15-0145153		
Date Assigned:	08/06/2015	Date of Injury:	09/28/2001
Decision Date:	09/15/2015	UR Denial Date:	07/09/2015
Priority:	Standard	Application Received:	07/27/2015

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: New York
 Certification(s)/Specialty: Internal Medicine

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 59-year-old male, who sustained an industrial injury on 09-28-2001. The injured worker is currently off work. The injured worker is currently diagnosed as having psychogenic headache, generalized convulsive epilepsy, cervical radiculopathy, cervicobrachialgia, low back pain, and lumbosacral neuritis. Treatment and diagnostics to date has included medications. In a progress note dated 06-04-2015, the injured worker reported significant headaches and neck pain. Objective findings included cervical spine tenderness and decreased range of motion. The treating physician reported requesting authorization for retrospective Azithromycin, Ketoconazole cream, Mirtazapine, Oxybutynin, and Tamsulosin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Azithromycin 250 MG DOS 10/16/13: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Infectious Disease chapter, Azithromycin (Zithromax).

Decision rationale: Regarding the request for Azithromycin (Zithromax), California MTUS Guidelines are silent. Official Disability Guidelines (ODG) recommend Azithromycin (Zithromax) "as a first-line treatment for chronic bronchitis and other conditions. . . Guidelines increasingly recommend that certain antibiotics, particularly the macrolide azithromycin, no longer be used to treat many common infections. Inappropriate use has led to widespread antibiotic resistance and is contributing to the emergence of super bugs. The use of narrow- spectrum antibiotics instead would result in a fall in their resistance rates". After review of the medical records, there is no documentation as to why the injured worker is being prescribed Azithromycin. It is noted that the antibiotic was prescribed on 10-16-2013, but there are no progress notes submitted for that time frame. Therefore, based on the Guidelines and the submitted records, the request for retrospective Azithromycin is not medically necessary.

Retro Ketoconazole 2 Percent DOS 10/16/13: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Uptodate.

Decision rationale: Ketoconazole, Imidazole Derivative is an Antifungal Cream used for treatment of tinea corporis, tinea cruris, tinea versicolor, cutaneous candidiasis, seborrheic dermatitis. Review of submitted medical records do not provide clear rationale to support the use of this medication in this injured worker. There is no documentation of symptoms, clinical findings or diagnosis to justify its use. Based on the currently available information, the medical necessity for this requested treatment Retro Ketoconazole 2 Percent has not been established.

The requested treatment is not medically necessary

Retro Mirtazapine 15 MG DOS 1/7/13: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress chapter, Antidepressants.

Decision rationale: According to California MTUS Chronic Pain Medical Treatment Guidelines, Antidepressants for chronic pain are "recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) 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. (Saarto-Cochrane, 2005) Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological

assessment". In addition, Guidelines also state that "no studies have specifically studied the use of antidepressants to treat pain from osteoarthritis. (Perrot, 2006) In depressed patients with osteoarthritis, improving depression symptoms was found to decrease pain and improve functional status. (Lin-JAMA, 2003)" According to Official Disability Guidelines (ODG), Antidepressants are "recommended, although not generally as a stand-alone treatment. Antidepressants have been found to be useful in treating depression (Furukawa, 2002) (Joffe, 1996), including depression in physically ill patients (Gill, 1999), as well as chronic has associated with depression". After review of received medical records, there is no documentation as to why the injured worker is being prescribed Mirtazapine (Remeron) or the response to taking this medication. Therefore, the request for retrospective Mirtazapine is not medically necessary.

Retro Oxybutynin Chloride 5 MG DOS 3/28/13: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Uptodate.

Decision rationale: Oxybutynin is used for treatment of symptoms associated with overactive uninhibited neurogenic or reflex neurogenic bladder (eg, urgency, frequency, leakage, urge incontinence, dysuria); treatment of symptoms associated with detrusor overactivity due to a neurological condition (eg, spina bifida) (extended release tablet only). Review of submitted medical records do not provide clear rationale to support the use of this medication in this injured worker. There is no documentation of symptoms, clinical findings or diagnosis to justify its use. Based on the currently available information, the medical necessity for this requested treatment Retro Oxybutynin Chloride 5 MG has not been established. The requested treatment is not medically necessary.

Retro Tamsulosin ER .4 MG DOS 12/12/13: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Uptodate.

Decision rationale: Tamsulosin is an Alpha 1 Blocker used for treatment of signs and symptoms of benign prostatic hyperplasia (BPH). Review of submitted medical records do not provide clear rationale to support the use of this medication in this injured worker. There is no documentation of symptoms, clinical findings or diagnosis to justify its use. Based on the currently available information, the medical necessity for this requested treatment Retro Tamsulosin ER .4 MG has not been established. The requested treatment is not medically necessary.