

Case Number:	CM15-0204390		
Date Assigned:	10/21/2015	Date of Injury:	07/07/2006
Decision Date:	12/31/2015	UR Denial Date:	09/25/2015
Priority:	Standard	Application Received:	10/19/2015

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: Oregon

Certification(s)/Specialty: Plastic Surgery, Hand Surgery

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 46 year old male with an industrial injury dated 07-07-2006. A review of the medical records indicates that the injured worker is undergoing treatment for failed back surgery syndrome, lumbar radiculopathy, status post fusion of lumbar spine, iatrogenic opioid dependency status post intrathecal pump implant; and status post spinal cord stimulator implant-failed. According to the progress note dated 08-24-2015, the injured worker reported low back pain with radiation into the bilateral lower extremities. The pain is aggravated with activity and walking. Pain level was 5 out of 10 with medications and 8-9 out of 10 without medications on a visual analog scale (VAS). The injured worker reported that the pain is unchanged since last visit. Documentation noted the injured worker is attempting to wean opiate usage. Objective findings (07-02-2015, 07-27-2015, 08-10-2015, 08-24-2015) revealed tenderness to palpitation at L4-S1, spasms, myofascial trigger points with twitch response, moderated limited lumbar range of motion secondary to pain, and moderate decrease strength in the right lower extremity. Sensory exam was within normal limits. Treatment has included X-ray of thoracic spine 11-15-2012, Magnetic Resonance Imaging (MRI) of lumbosacral spine 08-08-2011, lumbosacral spine series 08-08-2011, CT of lumbar spine dated 01-30-2014, Ibuprofen (since at least 2014), Norco (since at least 2014), Tizanidine (since at least 2014), Compazine (since at least 2014), Prochlorperazine (since at least 2014), and periodic follow up visits. The treating physician reported no inconsistencies in CURES report dated 05-18-2015. The injured worker is currently not working. The treatment plan included aqua pool therapy and continuation of current medications. The utilization review dated 09-25-2015, non-certified the request for one (1)

prescription of Prochlorperazine 10mg #60, one (1) prescription of Compazine 10mg #90, one (1) prescription of Norco 10-325mg #20, one (1) prescription of Ibuprofen 800mg #60, and one (1) prescription of Tizanidine 4mg #15.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) prescription of Prochlorperazine 10mg #60: 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), Pain: Antiemetics (for opioid nausea).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drug treatment of adults with nausea and vomiting in primary care. Furyk JS, Meek R, McKenzie S. BMJ. 2014 Aug 7; 349:g4714.

Decision rationale: The patient has been on prochlorperazine for at least two years. The records do not provide a clear explanation for why this medication is still required. Opiate weaning has been initiated and this should decrease any opiate induced nausea. The request is not medically necessary.

One (1) prescription of Compazine 10mg #90: 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), Pain: Antiemetics (for opioid nausea).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drug treatment of adults with nausea and vomiting in primary care. Furyk JS, Meek R, McKenzie S.

Decision rationale: The patient has been on prochlorperazine for at least two years. The records do not provide a clear explanation for why this medication is still required. Opiate weaning has been initiated and this should decrease any opiate induced nausea. The request is not medically necessary.

One (1) prescription of Norco 10/325mg #20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Acetaminophen, Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment.

Decision rationale: Per ACOEM, Initial Approaches to Treatment, page 47 and 48, OPIOIDS: Opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time. The patient has been on chronic opiates. The opiates are being weaned slowly. ACOEM supports opiates only for short term treatment. The request is for chronic maintenance. The request is not medically necessary because it exceeds ACOEM guidelines.

One (1) prescription of Ibuprofen 800mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: Per MTUS page 67, "Back Pain - Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen." "Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief." The patient has been on long term Ibuprofen use. MTUS supports only limited use of this medication. The request is not medically necessary.

One (1) prescription of Tizanidine 4mg #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: Per MTUS page 63, Muscle relaxants: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP". The patient has been on longstanding muscle relaxant medications. MTUS does not support long term use of these medications. Because the request is for chronic rather than acute treatment, it is not medically necessary.