MAXIMUS Federal Services

Case Number:	CM15-0048451		
Date Assigned:	03/20/2015	Date of Injury:	06/26/2014
Decision Date:	05/06/2015	UR Denial Date:	03/03/2015
Priority:	Standard	Application Received:	03/13/2015

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
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 49 year old male, who sustained an industrial injury on 06/26/2014. He has reported subsequent back pain and was diagnosed with lumbar musculoligamentous strain. Treatment to date has included oral pain medicine. The only medical documentation submitted is an initial neurological consultation note dated 09/23/2014. According to this progress note, the injured worker complained of constant back pain that radiated to the left lower extremity along with numbness and tingling. The physical examination revealed that the ROM of the cervical exam and of bilateral shoulders was within normal limits, and motor testing of upper and lower limbs was within normal limits. There was no medical documentation submitted that pertains to the current treatment request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg #30: 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), Proton Pump Inhibitors (PPIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 68-69 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton Pump Inhibitors (PPIs).

Decision rationale: Regarding the request for Prilosec 20mg #30, California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested Prilosec 20mg #30 is not medically necessary.

Zanaflex 2mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain), Antispasticity Drugs. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

Decision rationale: Regarding the request for Zanaflex (tizanidine) 2mg #120, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that tizanidine specifically is FDA approved for management of spasticity; unlabeled use for low back pain. Guidelines recommend LFT monitoring at baseline 1, 3, and 6 months. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the tizanidine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, it does not appear that there has been appropriate liver function testing, as recommended by guidelines. In the absence of such documentation, the currently requested Zanaflex (tizanidine) 2mg #120 is not medically necessary.

Sonata 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) Chronic Pain, Sleep Medication, Insomnia treatment.

Decision rationale: Regarding the request for Sonata 10mg #30, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use

(usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to Sonata treatment. Finally, there is no indication that Sonata is being used for short-term use as recommended by the guidelines. In the absence of such documentation, the currently requested Sonata 10mg #30 is not medically necessary.

Right shoulder diagnostic ultrasound: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Table 9-6, 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Diagnostic Ultrasound.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

Decision rationale: Regarding the request for right shoulder diagnostic ultrasound, California MTUS cites that ultrasonography for evaluation of rotator cuff is not recommended. Within the documentation available for review, there is no documentation of subjective/objective findings consistent with a condition/diagnosis for which ultrasound is supported. In the absence of such documentation, the currently requested right shoulder diagnostic ultrasound is not medically necessary.

MRI neck: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Table 8-4, 172. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back, Indications for MRI (magnetic resonance imaging).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck Chapter, MRI.

Decision rationale: Regarding the request for an MRI of the neck, guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Guidelines also recommend MRI after 3 months of conservative treatment. Within the documentation available for review, there is no indication of any red flag diagnoses. Additionally there is no documentation of neurologic deficit or failure of conservative treatment for at least 3 months. In the absence of such documentation the requested MRI of the neck is not medically necessary.