MAXIMUS Federal Services

Case Number:	CM14-0129729		
Date Assigned:	08/20/2014	Date of Injury:	07/05/2011
Decision Date:	09/30/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	08/14/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Texas and Ohio. 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 injured worker is a 41-year-old male who reported an injury on 07/05/2011 due to unloading lumber off a lumber rack and a support came loose and a board came down knocking the injured worker back and onto the ground. The injured worker had a history of back pain, right leg, left leg, mid back, hip, back of both legs and right hip pain. The injured worker had a diagnoses of lower back pain with radiculopathy, thoracic spine pain, cervicalgia, bilateral shoulder pain intermittent, bilateral foot pain and ankle pain secondary to radiculopathy. The MRI dated 08/13/2011 revealed mild dextroconvex at the thoracic lumbar junction with a grade 1 approximately 2 to 3 mm retrolisthesis at the L5-S1, hypertrophic facet joint arthrosis at L2-3, mild right facet joint arthrosis at L5-S1 and broad based disc protrusion at the L5-S1. Past treatments included lumbar epidural steroid injection and medication. The past surgeries included a status post fusion with cadaver bone on 10/21/2013. The medications included Donnatal, Lorazepam, Norco, Naratriptan, Inderal, Lunesta, MS Contin, Tizanidine, Duloxetine, Gabapentin and Ibuprofen with a reported pain level of 6/10, using the VAS. A urinalysis was collected on 07/18/2014. The objective findings dated 08/04/2014 to the musculoskeletal revealed gait and station examination with abnormalities, inspection and palpation of bones, joints, muscles was unremarkable, muscle strength to the bilateral hips external rotation, bilateral hips internal rotation, bilateral hip flexors, bilateral quadriceps, bilateral gluteal muscles, bilateral hamstrings, bilateral feet dorsal flexors, and bilateral foot plantar flexors were 5-/5. The examination of the lumbar sacral revealed positive pelvic thrust to the left pain noted to palpation over the L3-4, L4-5, and L5-S1 facet capsules to the left. The treatment plan included continue medications, and undergo and repeat RF. The Request for Authorization dated 07/09/2014 was submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydroco APAP 10/325mg #360: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management; Hydrocodone/Acetaminophen Page(s): 78; 91.

Decision rationale: The request for Hydroco APAP 10/325mg #360 is not medically necessary. The California MTUS guidelines indicate that Tylenol w/ Codeine 3 should be used for moderate to severe pain and there should be documentation of the 4 A's for Ongoing Monitoring including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. The documentation did not indicate the activities of daily living. The request did not indicate the frequency. As such, the request is not medically necessary.

Gabapentin 600mg #270 with 1 refill: Upheld

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

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

Decision rationale: The request for Gabapentin 600mg #270 with 1 refill is not medically necessary. The California MTUS guidelines indicate that Gabapentin is shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The clinical notes did not indicate that the injured worker had diagnosis or history of diabetic neuropathy or postherpetic neuralgia. The request did not indicate the frequency. As such, the request is not medically necessary.

Eszopiclone tab 3mg #30 with 1 refill: Upheld

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

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

Decision rationale: The request for Eszopiclone tab 3mg #30 with 1 refill is not medically necessary. The Official Disability Guidelines indicates the use of Lunesta is for the short-term treatment of insomnia, generally 2 - 6 weeks. The clinical notes do not indicate that the injured

worker had a history or diagnosis of insomnia. The guidelines indicate short term treatment for insomnia, generally 2 to 6 weeks. The request did not indicate frequency. As such, the request is not medically necessary.

Lorazepam 0.5mg #120 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Page(s): 24.

Decision rationale: The request for Lorazepam 0.5mg #120 with 3 refills is not medically necessary. The California MTUS guidelines do not recommend benzodiazepines for long-term use and most guidelines limit use to 4 weeks. The clinical notes indicate that the injured worker was prescribed Lorazepam on 11/18/2013 and again was prescribed the Lorazepam on 08/11/2014. The guidelines recommend no more than 4 weeks. The clinical notes indicate that the injured worker has exceeded the time frame. The request did not indicate frequency. As such, the request is not medically necessary.

Tizanidine 4mg #90 with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

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

Decision rationale: The request for Tizanidine 4mg #30 is not medically necessary. The California MTUS guidelines recommend Tizanidine (Zanaflex) as non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Guidelines indicate Tizanidine as a second line muscle relaxant. No documentation of efficacy. The clinical notes indicate that the injured worker had been taking the Tizanidine from 11/18/2013. The guidelines recommend for short term use. The request did not address the frequency. The request is not medically necessary.

Ibuprofen 600mg #90 with 4 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Laboratory Testing, NSAIDS Page(s): 70.

Decision rationale: The request for Ibuprofen 600mg #90 with 4 refills is not medically necessary. The California MTUS guidelines indicate that the package inserts for NSAIDs

recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established. The documentation was not evident of any lab other than drug screen. The request did not address the frequency. As such, the request is not medically necessary.

Duloxetine 60mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs (selective serotonin reuptake inhibitors); Trazadone, Prozac, Fluoxetine Page(s): 107.

Decision rationale: The request for Duloxetine 60mg #30 is not medically necessary. The California MTUS guidelines indicate that SSRI's are not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. SSRIs have not been shown to be effective for low back pain. The guidelines recommend not to use a selective serotonin reuptake inhibitor for chronic pain. The request did not indicate the frequency. As such, the request is not medically necessary.