

Case Number:	CM14-0145987		
Date Assigned:	09/12/2014	Date of Injury:	09/04/2003
Decision Date:	10/15/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	09/08/2014

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 Internal Medicine, has a subspecialty in Pulmonary Disease and is licensed to practice in California. 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 48-year-old male who reported an injury on 09/04/2003 of an unspecified mechanism of injury. The injured worker complained of lower back pain and left lower extremity pain. The injured worker had diagnoses of lumbar degenerative disc disease, lower back pain, lumbosacral radiculitis, and lumbar spondylosis without myelopathy at multiple levels, moderate foraminal stenosis bilaterally at the L3-4 and the L4-5, and spasticity to the left lower extremity. The prior surgeries included lumbar spine discectomy in 2003. The diagnostic studies included an electromyogram to the lower extremities and an MRI of the lumbar spine dated 02/27/2014, that revealed straightening of the lumbar lordosis suggestive of spasms, multilevel facet arthropathy, and ligamentum flavum hypertrophy with moderate foraminal stenosis at the L3-4 and the L4-5 vertebra endplate edema mild disc bulge. Past treatments included physical therapy, TENS unit, home exercise program, medication, and biofeedback. The medications included Tizanidine, Naproxen, Norco, and over the counter Naproxen. Physical examination dated 05/14/2014, to the lumbar spine revealed straight non-tender, decreased range of motion with pain, mild left facet tenderness, no sacroiliac tenderness, and left L4-5 paravertebral spasms. The lower extremities revealed grossly normal, non-tender, foot drop left, no swelling, edema, masses, lesions, or dislocation. Straight leg raise on the left was negative. Neurological examination voluntary versus involuntary tapping movement of the left lower extremity was completed. The treatment plan included the Naproxen, Amitriptyline, Tizanidine, and Gabapentin. The Request for Authorization dated 05/15/2014 was submitted with the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen 500mg #60 with 2 refills.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

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

Decision rationale: The request for Naproxen 500 mg #60 with 2 refills is not medically necessary. The California MTUS Guidelines indicate that proton pump inhibitors may be recommended for injured workers with dyspepsia secondary to non-steroidal anti-inflammatory drugs (NSAIDs) therapy or for those taking NSAIDs medication that are at moderate to high risk for gastrointestinal events. The clinical notes were not evident that the injured worker has had a history or diagnosis of gastrointestinal issues. The request did not address the frequency. As such, the request for Naproxen 500 mg #60 with 2 refills is not medically necessary.

Amitriptyline HCL 50mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13.

Decision rationale: The request for Amitriptyline HCL 50 mg #60 is not medically necessary. The California MTUS recommends Amitriptyline is a tricyclic antidepressant. Tricyclics are generally considered a first line agent unless they are ineffective, poorly tolerated, or contraindicated. It is recommended that these outcome measures should be initiated at 1 week of treatment with a recommended trial of at least 4 weeks. The optimal duration of treatment is not known because most double blind trials have been of short duration with just 6 to 12 weeks. Long term effectiveness antidepressants have not been established. Assessment of treatment efficacy should include not only pain outcomes, but also evaluation of function, changes in use of other analgesic medications, sleep quality, duration, and psychological assessment. The clinical notes dated 5/14/2014, were not evident of the efficacy of the Amitriptyline. The request did not indicate the frequency. As such, the request for Amitriptyline HCL 50 mg #60 is not medically necessary.

Tizanidine HCL 4mg #90 with 2 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 HCL 4 mg #90 with 2 refills is not medically necessary. The California MTUS Guidelines recommend Tizanidine (Zanaflex) as a non-sedating muscle relaxant with caution as a second line option for short term treatment of acute exacerbations in patients with chronic lower back pain. The clinical note indicated that the injured worker stated that these medications are not helping him and he was doing well on the medication regimen he came in on. The request did not indicate the frequency. As such, the request for Tizanidine HCL 4 mg #90 with 2 refills is not medically necessary.

Gabapentin 600mg #90 with 2 refills.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs).

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

Decision rationale: The request for Gabapentin 600 mg #90 with 2 refills is not medically necessary. The California MTUS Guidelines state Gabapentin has been shown to be diabetic painful neuropathy and postherpetic neuralgia and has been considered a first line treatment in neuropathic pain. After initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with the use. The clinical notes dated 05/14/2014, indicate that the injured worker stated that this medication was not helping him. The injured worker did not have a diagnosis of diabetic neuropathy or postherpetic neuralgia. The request did not indicate frequency. As such, the request for Gabapentin 600 mg #90 with 2 refills is not medically necessary.