MAXIMUS Federal Services

Case Number:	CM15-0041737		
Date Assigned:	03/11/2015	Date of Injury:	06/13/2003
Decision Date:	05/18/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	03/05/2015

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: Anesthesiology

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 female, who sustained an industrial injury on June 13, 2003. The injured worker had reported low back pain. The diagnoses have included moderate disc collapse of lumbar five-sacral one, lumbosacral discogenic disease, lumbosacral spondylosis, pathological fracture of the vertebra and chronic low back pain. Treatment to date has included medications, radiological studies, trigger point injection, epidural steroid injections and a home exercise program. Current documentation dated January 27, 2015 notes that the injured worker reported low back pain with radiation to the lower extremities, which increased with activities. Physical examination of the lumbar spine revealed pain, spasms, guarding and a restricted range of motion. A straight leg raise test was positive on the left. The treating physician's plan of care included a request for chiropractic treatment to reduce pain and increase function and the medications Tylenol #4, Protonix and Zanaflex.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 chiro lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Page(s): 58.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299.

Decision rationale: According to the CA MTUS, Manual Therapy or Chiropractic therapy, is recommended for chronic pain if it is caused by musculoskeletal conditions. The intended goal or effect is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. For the treatment of low back pain, a trial of 6 visits is recommended over 2 weeks, with evidence of objective improvement, with a total of up to 18 visits over 6-8 weeks. If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. In this case, the requested number of sessions exceeded the MTUS recommendation. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Tylenol #4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines, Pain chapter Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: Tylenol with Codeine (Tylenol #3, Tylenol #4) is a short-acting opioid analgesic, and is in a class of drugs that has a primary indication to relieve symptoms related to pain. It is recommended as an option for mild to moderate pain. Codeine is a schedule C-II controlled substance, but codeine with acetaminophen is a C-III controlled substance. It is similar to morphine. 60 mg of codeine is similar in potency to 600 mg of acetaminophen. Tylenol #4 has twice as much codeine as Tylenol #3. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. In addition, there is no documentation of the dosage and amount requested. Medical necessity of the requested item has not been established. The certification of the requested medication is not recommended.

Protonix: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to CA MTUS (2009), proton pump inhibitors, such as Protonix (Pantoprazole), are recommended for patients at risk for gastrointestinal events or taking NSAIDs with documented GI distress symptoms. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation of any reported GI complaints. In addition, there is no documentation of the dosage and amount requested. Based on the available information provided for review, the medical necessity for Protonix has not been established. The requested medication is not medically necessary.

Zanaflex: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63, 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Muscle Relaxants.

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and considered an adjunct treatment for fibromyalgia. According to CA MTUS Guidelines, muscle relaxants have not been considered any more effective than non-steroidal anti-inflammatory drugs (NSAIDs) for pain or overall improvement. There is no additional benefit shown in combination with NSAIDs. In addition, sedation is the most commonly reported adverse effect of muscle relaxant medications. In this case, the patient has no clear documentation of acute muscle spasm on physical exam. In addition, there is no documentation of the dosage and amount requested. The guideline criteria do not support the long-term (>2 wks) use of muscle relaxants. Medical necessity for the requested medication has not been established. The requested medication, Zanaflex, is not medically necessary.