MAXIMUS Federal Services

Case Number:	CM15-0079630		
Date Assigned:	04/30/2015	Date of Injury:	06/26/2014
Decision Date:	06/11/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	04/25/2015

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: Emergency Medicine

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 6/26/2014. He reported tripping and falling down two stairs onto his buttocks. The injured worker was diagnosed as having lumbar spine sprain/strain, bilateral shoulder sprain/impingement, bilateral hip sprain, bilateral epicondylitis, and bilateral plantar fasciitis of feet. Treatment to date has included aquatic therapy, medications, rest, and a home exercise program. A PR-2 dated 3/13/2015, documents reports of continued right shoulder and left hip pain. He also reported weight gain, heartburn, and fatigue, incontinence of urine, headaches, and memory loss and concentration difficulties. The provider noted there had been no changes to the cervical spine, lumbar spine, left shoulder, bilateral hip and bilateral feet. The treatment plan included: starting Remeron for sleeping difficulties, follow up in 5-6 weeks, AME/QME evaluation, urology consultation, electro diagnostic studies, and left hip surgical consultation. The IW remained temporarily totally disabled. On April 8, 2015, Utilization Review certified a request for a random urine sample. A request for Tylenol and Codeine #3 was modified and requests for Zanaflex, Remeron, and EMG/NCV studies for bilateral upper and lower extremities were non certified. Ca MTUS chronic pain guidelines were cited in support of these decisions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tylenol #3, 300/30mg quantity 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opiod Page(s): 77-81.

Decision rationale: CA MTUS, chronic pain guidelines, offer very specific guidelines for the ongoing use of narcotic pain medication to treat chronic pain. These recommendations state that the lowest possible dose be used as well as ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects. It also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the medications. The included documentation fails to include the above recommended documentation. The IW has been taking this medication for a minimum of 6 months. Documentation does not support a decrease in pain or change in functional status, as the IW remains TTD. In addition, the request does not include dosing frequency or duration. The request for Tylenol and Codeine #3 is not medically necessary.

Tizanidine 2mg quantity 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants; Tizanidine Page(s): 63-64; 66.

Decision rationale: According to CA MTUS, Tizanidine is a centrally acting alpha2-adrenerfic agonist. It is in the class of muscle relaxants. Muscle relaxants are recommended as an option for short course of therapy. Effect is noted to be modest and is greatest in the first 4 days of treatment. The IW has been receiving this prescription for a minimum of 6 months according to submitted records. This greatly exceeds the recommended timeframe of treatment. In addition, the request does not include dosing frequency or duration. The IW's response to this medication is not discussed in the documentation. The request is not medically necessary.

Remeron 15mg quantity 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, Insomnia.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress.

Decision rationale: According to CA-MTUS, antidepressants are recommended as first line agent for neuropathic pain and non-neuropathic pain in specific cases. The documentation submitted for review indicates the IW is being prescribed for sleep. ODG recommends anti-depressant use to treat depression in physically ill patients. Neither of the reference supports the use of antidepressants, specifically Remeron, for sleep. Additionally, the request does not include dosing or frequency. Without the support of recommendations, the request for Remeron is not medically necessary.

Electromyography/Nerve Conduction Studies of bilateral lower and upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 62. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Electromyography.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 168-171; 303-304.

Decision rationale: There are no reports from the prescribing physician, which adequately document neurologic findings leading to medical necessity for electro diagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electro diagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. Non-specific, non-dermatomal extremity symptoms are not sufficient alone to justify electro diagnostic testing. The MTUS, per the citations listed above, outlines specific indications for electro diagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. The clinical evaluation is minimal and there is no specific neurological information showing the need for electro diagnostic testing. For example, a diagnosis of radiculopathy should be supported by the signs and symptoms listed in the MTUS cited above. Based on the recent clinical information, there are no neurologic abnormalities and no specific neurologic symptoms. Based on the current clinical information, electro diagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.