

Case Number:	CM14-0116524		
Date Assigned:	08/04/2014	Date of Injury:	11/08/1999
Decision Date:	11/04/2014	UR Denial Date:	07/15/2014
Priority:	Standard	Application Received:	07/24/2014

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 Oklahoma. 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 47-year-old female who reported an injury on 11/08/1999. The mechanism of injury was not submitted for clinical review. Diagnoses included cervicgia, post-laminectomy syndrome of the lumbar region, pain in the joint, trochanteric bursitis, unspecified myalgia and myositis, and long term current use of other medications. The previous treatments included medication, surgery, and epidurogram. Within the clinical note dated 06/23/2014, it was reported the injured worker complained of low back pain. She reported the low back pain radiated to the lower extremity. On physical examination, the provider noted the injured worker had very limited range of motion of her neck with tenderness over the left cervical facets and palpable knots in the left shoulder. The range of motion was limited with 45 degrees of motion. The provider noted tenderness to palpation of the paraspinals. He indicated the injured worker had tenderness over the myofascial bend in the levator scapulae on the left causing significant limitation in range of motion. Upon the examination of the thoracic spine, the provider noted the injured worker had tenderness to palpation. The request submitted is for Ativan for severe spasms, Soma for spasms, and Duragesic for pain. The request for authorization was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ativan 1mg #60; Refill: 2: Upheld

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

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

Decision rationale: The request for Ativan 1mg #60; Refill: 2 is not medically necessary. The California MTUS Guidelines do not recommend Ativan for long term use due to the long term efficacy being unproven and there is risk of dependence. The guidelines also recommend the limited use of Ativan to 4 weeks. The injured worker has been utilizing the medication since at least 01/2014 which exceeds the guideline recommendation of short term use of 4 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Soma 350mg #90; Refill: 2: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

Decision rationale: The request for Soma 350mg #90; Refill: 2 is not medically necessary. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. The injured worker has been utilizing the medication since at least 01/2014. Therefore, the request is not medically necessary.

Duragesic 100mcg / hour #15: 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 Topical NSAIDs Page(s): 111-112.

Decision rationale: The request for Duragesic 100mcg / hour #15 is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for osteoarthritis and tendonitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the

injured worker has been utilizing the medication since at least 01/2014 which exceeds the guideline recommendation of short term use of 4 to 12 weeks. Therefore, the request is not medically necessary.