

Case Number:	CM14-0026341		
Date Assigned:	06/13/2014	Date of Injury:	03/21/2003
Decision Date:	07/16/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	03/03/2014

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 Neurological Surgery 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 49 year old female reportedly injured on 3/21/2003. The mechanism of injury is not listed. The most recent progress note dated 1/27/2014, indicates that there are ongoing complaints of neck pain that radiates down the right upper extremity, and low back pain that radiates down both lower extremities. Physical examination demonstrated myofascial trigger points and spasming in the trapezius/rhomboid muscles; severely limited cervical range of motion due to pain; decreased sensation in the C6/7 dermatome bilaterally; tenderness and spasm to L4-S1 area; severely limited lumbar range of motion due to pain; decreased sensation in the L4-S1 dermatome on the right; straight leg raise positive for right radicular pain at 30. MRI of the lumbar spine dated 6/29/2010 and 5/11/2013 demonstrated 2-3 mm central disc bulge without canal or foraminal stenosis at L3/4; 3-4 mm disc bulge with a focal disc extrusion resulting in mild bilateral foraminal stenosis at L4/5; 4-5 mm disc bulge and facet arthropathy resulting in mild to moderate bilateral foraminal stenosis at L5/S1 with degenerative endplate changes and edema. MRI of the cervical spine dated 5/11/2013 demonstrated mild left foraminal narrowing at C4/5; mild canal stenosis and severe bilateral foraminal narrowing at C5/6. Diagnosis: cervical radiculopathy; lumbar disc degeneration and facet arthropathy; and lumbar radiculopathy. Previous treatment includes epidural steroid injection and the following medications: Celexa, Lyrica, Norco, Robaxin, Valium, Skelaxin, Ibuprofen and Nucynta ER. A request had been made for one Toradol 60 mg with B-12 1000 mcg; Valium 10 mg #60 Robaxin 750 mg #60; and Ibuprofen 800 mg #30. A utilization review on 2/17/2014 non-certified the Toradol injection with B-12, Robaxin and Ibuprofen. Valium 10 mg was modified and partially certified for #24.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE TORADOL 60 MG INJECTION WITH B-12 1000 MCG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) - Chronic Pain; Medications - Vitamins (electronically sited) and Official Disability Guidelines (ODG), TWC Integrated Treatment/Disability Duration Guidelines: Pain (Chronic) - Toradol (updated 06/10/14).

Decision rationale: The American College of Occupational and Environmental Medicine (ACOEM) specifically recommends against the use of dietary supplements (B-12) in the treatment of chronic pain. These supplements have not been shown to produce any meaningful benefits or improvements in functional outcomes. California Medical Treatment Utilization Schedule (CAMTUS) does not address intramuscular Toradol injections. Official Disability Guidelines (ODG) support intramuscular Toradol injections as an alternative to opiate therapy. The claimant is currently taking long-term opioids as well as an oral NSAID. Per current treatment guidelines, this request is not medically necessary.

ONE PRESCRIPTION OF VALIUM 10 MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009 Benzodiazepines) Page(s): 24.

Decision rationale: Chronic Pain Medical Treatment Guidelines do not support benzodiazepines (Valium) for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. As such, this request is not medically necessary.

ONE PRESCRIPTION OF ROBAXIN 750 MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 65.

Decision rationale: Chronic Pain Medical Treatment Guidelines classify Robaxin (Methocarbamol) as a muscle relaxant; however, the mechanism of action is unknown, but appears to be related to central nervous system depressant effects with related sedative properties. Given the claimant's chronic pain, current medications and documented history of depression, this request is not medically necessary.

ONE PRESCRIPTION OF IBUPROFEN 800 MG #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 22.

Decision rationale: Chronic Pain Medical Treatment Guidelines support the use of anti-inflammatories as the traditional first-line of treatment to reduce pain and inflammation to increase function. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective nonsteroidal anti-inflammatory drugs (NSAIDs) in chronic LBP. Given the claimants chronic low back pain, this request is medically necessary.