MAXIMUS Federal Services

Case Number:	CM14-0032136		
Date Assigned:	06/20/2014	Date of Injury:	07/11/2005
Decision Date:	09/29/2014	UR Denial Date:	02/21/2014
Priority:	Standard	Application Received:	03/13/2014

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 and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 48-year-old individual was reportedly injured on July 11, 2005. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated February 7, 2014, indicated that there were ongoing complaints of low back pain. The physical examination demonstrated no tenderness of the lumbar spine with a decrease lumbar spine range of motion. Diagnostic imaging studies objectified the lumbar fusion mass. Previous treatment included lumbar fusion, physical therapy, multiple medications and pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on February 21, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg#60 for lumbar spine: 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 Page(s): 74-78, 88, 91.

Decision rationale: As outlined in the MTUS, this medication is indicated for moderate to severe breakthrough pain. The progress notes indicate that this is a constant, indefinite protocol.

However, the progress notes did not demonstrate any efficacy in terms of increased functionality or decrease in pain complaints. Therefore, when considering the parameters noted in the MTUS and by the physical examination findings and the response to pain, there does not appear to be any clinical indication or medical necessity for continued use of this medication based on the lack of efficacy.

Robaxin 750 mg #30 for lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 65.

Decision rationale: Robaxin is a muscle relaxant intended as a second line option for short-term treatment of acute exacerbations of chronic low back pain. According to the progress notes and in the attached medical record, there has been no report of any acute exacerbations of low back pain or any spasms noted on physical examination. Considering this, the request for Robaxin is not medically necessary.

Ambien 10 mg #30 for lumbar spine: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain chapter, updated September 2014.

Decision rationale: This medication is not addressed in the MTUS or the ACOEM guidelines. The parameters noted in the ODG were employed. This is a short acting non-benzodiazepine hypnotic. This is approved for short-term use (2-6 weeks) for the treatment of insomnia. This is not indicated for chronic or indefinite use. Therefore, based on the progress notes presented for review, and noting that there has not been any critical analysis of the sleep hygiene, and by the parameters outlined in the MTUS, this is not medically necessary.