

Case Number:	CM14-0053626		
Date Assigned:	07/07/2014	Date of Injury:	04/19/2006
Decision Date:	08/18/2014	UR Denial Date:	04/10/2014
Priority:	Standard	Application Received:	04/22/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas & 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 48-year-old male who reported an injury on 04/19/2006. The mechanism of injury was not specifically stated. Current diagnoses included chronic back pain, left S1 radiculopathy, lumbar degenerative disc disease/spondylolisthesis, cervical disc disease, possible cervical radiculopathy, postconcussion syndrome, pain related insomnia, pain related depression, possible post-traumatic stress disorder, and erectile dysfunction. The injured worker was evaluated on 03/28/2014. Current medications include Norco 10/325 mg, Flexeril 10 mg, Lyrica 150 mg, and Ambien 10 mg. The injured worker reported chronic neck and lower back pain with spasm and radicular symptoms in the left lower extremity. The injured worker reported 50% reduction in symptoms with the current medication regimen. Physical examination on that date revealed tenderness overlying the bilateral temporomandibular joints, a well-healed midline abdominal scar, slight swelling in the left abdomen, hyperesthesia in the left abdomen at the T10 and T11 dermatomes, slight tenderness in the lower cervical spine, tenderness noted in the upper thoracic spine, a well-healed midline incision in the lumbar spine, tenderness to palpation of the lumbar spine, 2+ deep tendon reflexes in the upper and lower extremities, and 5/5 motor strength. Treatment recommendations at that time included authorization for a psychological consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 10 mg (quantity unknown): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: The California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations. Flexeril should not be used for longer than 2 to 3 weeks. As per the documentation submitted, the patient has continuously utilized Flexeril since 2009. There is no documentation of objective functional improvement. There is no evidence of palpable muscle spasm or spasticity upon physical examination. The California MTUS Guidelines do not recommend long-term use of muscle relaxants. There is no frequency or quantity listed in the current request. As such, the request is not medically necessary.

Ambien 10 mg (quantity unknown): 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 (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short-term of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker does maintain a diagnosis of insomnia. However, there is no documentation of objective functional improvement as a result of the ongoing use of this medication. There is also no frequency or quantity listed in the current request. As such, the request is not medically necessary.