

Case Number:	CM14-0053860		
Date Assigned:	07/07/2014	Date of Injury:	08/30/2012
Decision Date:	01/20/2015	UR Denial Date:	03/20/2014
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 and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 43-year-old female who reported an injury on 08/30/2012. The mechanism of injury occurred while the injured worker was twisting at the waist. The diagnosis included L5-S1 discogenic pain with left lower extremity radiculopathy. The injured worker's past treatments included physical therapy and trigger point injections. There were no official diagnostic imaging studies submitted for review. There was no relevant surgical history documented within the clinical notes. The subjective complaints on 03/16/2014 included low back pain. The physical examination revealed tenderness to the left paraspinal region and lumbar spine. There was also left sciatic notch tenderness. The straight leg raise test was mildly positive on the left. There was decreased sensation in the L5 and S1 distribution. The medications were noted to include Naproxen 500 mg, cyclobenzaprine 10 mg, and Ativan 1 mg. The treatment plan was to request physical therapy and to refill the medications. A request was received for Naprosyn 500 mg #60 with 1 refill, Cyclobenzaprine 10 mg #30 with 1 refill, and Ativan 1 mg #30 with 1 refill. The rationale for the request was not documented within the clinical notes. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naprosyn 500mg, #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

Decision rationale: The California MTUS Chronic Pain Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain and, in particular, for those with gastrointestinal, cardiovascular, or renovascular risk factors. The guidelines also state for acute exacerbations of chronic pain, NSAIDs are recommended as a second line treatment after acetaminophen. There was a lack of documentation in the clinical notes that a first line agent, such as acetaminophen, was tried and failed. In the absence of the above information, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Cyclobenzaprine 10mg, #30 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 64.

Decision rationale: The California MTUS Chronic Pain Guidelines state that cyclobenzaprine is recommended for a short course of therapy. The guidelines also state that cyclobenzaprine is not recommended to be used longer than 3 weeks. The request as submitted exceeds the guideline recommendations of 3 weeks. Given the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Ativan 1mg, #30 with 1 refill: Upheld

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

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

Decision rationale: The California MTUS Chronic Pain Guidelines state that benzodiazepines are not recommended for long term use because long term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. The request as submitted exceeds the guideline recommendation of 4 weeks of use. Given the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.