

Case Number:	CM15-0100403		
Date Assigned:	06/02/2015	Date of Injury:	07/02/2010
Decision Date:	07/08/2015	UR Denial Date:	04/24/2015
Priority:	Standard	Application Received:	05/26/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 56 year old female who sustained a work related injury July 2, 2010. Past history included asthma, irritable syndrome, arthritis, peripheral neuropathy, depression /anxiety, L5-S1 discectomy 1998, L5-S1 discectomy/laminectomy 2008, L3-L4 L4-L5 fusion, L5-S1 fusion, 2010, C6-7 laminectomy October, 2014, left ulnar nerve decompression October 2014. According to a secondary treating physician's progress report, dated April 7, 2015, the injured worker presented with complaints of chronic severe neck and low back pain with left lower extremity numbness, tingling, and weakness. Conservative treatment has included aquatic therapy, narcotic pain medication, TENS unit, psychologist and hypnosis. Interventional care has included nerve block/injections, epidural steroid injections, and lumbar RFA (radiofrequency ablation) with 90% pain relief for nearly a year. Her pain is rated 2/10 with medication and 10/10 without medication. Diagnoses are documented as spondylosis, lumbar; cervical radiculopathy; post-laminectomy syndrome, lumbar region; chronic pain syndrome. At issue, is the request for authorization for Percocet, Restoril, and Robaxin.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 tablets of Robaxin 500mg with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (1) Muscle relaxants (for pain), (2) Methocarbamol (Robaxin) Page(s): 63, 65.

Decision rationale: The claimant sustained a work injury in July 2010. She continues to be treated for chronic neck and radiating low back pain. Medications are referenced as decreasing pain from 10/10 to 2/10 and as allowing for improved mobility, function, and tolerance for activities of daily living and home exercises. When seen, there was cervical and lumbar paraspinal muscle tenderness with positive Spurling's testing. There was lumbar facet and left sacroiliac joint tenderness. There was decreased upper and lower extremity sensation and decreased left lower extremity strength. Medications include Percocet being prescribed at a total MED (morphine equivalent dose) of 60 mg per day. Restoril and Robaxin are being prescribed on a long-term basis. Robaxin is a muscle relaxant in the antispasmodic class. Although its mechanism of action is unknown, it appears to be related to central nervous system depressant effects with related sedative properties. Non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Its efficacy may diminish over time, and prolonged use may lead to dependence. In this case, Robaxin has been prescribed on a long-term basis. Continued prescribing is not medically necessary.

120 tablets of Percocet 10/325mg: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Weaning of Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (1) Opioids, criteria for use, (2) Opioids, dosing Page(s): 76-80, 86.

Decision rationale: The claimant sustained a work injury in July 2010. She continues to be treated for chronic neck and radiating low back pain. Medications are referenced as decreasing pain from 10/10 to 2/10 and as allowing for improved mobility, function, and tolerance for activities of daily living and home exercises. When seen, there was cervical and lumbar paraspinal muscle tenderness with positive Spurling's testing. There was lumbar facet and left sacroiliac joint tenderness. There was decreased upper and lower extremity sensation and decreased left lower extremity strength. Medications include Percocet being prescribed at a total MED (morphine equivalent dose) of 60 mg per day. Restoril and Robaxin are being prescribed on a long-term basis. When prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Percocet (oxycodone/acetaminophen) is a short acting combination opioid often used for intermittent or breakthrough pain. In this case, it is being prescribed as part of the claimant's ongoing management. There were no identified issues of abuse or addiction and medications are providing pain control, improved activities of daily living, and improved function. The total MED (morphine equivalent dose) was 120 mg per day consistent with guideline recommendations. Therefore, the prescribing of Percocet was medically necessary.

30 capsules of Restoril 30mg with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment for Workers' Compensation (ODG TWC) Online Edition Chapter: Mental Illness & Stress.

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

Decision rationale: The claimant sustained a work injury in July 2010. She continues to be treated for chronic neck and radiating low back pain. Medications are referenced as decreasing pain from 10/10 to 2/10 and as allowing for improved mobility, function, and tolerance for activities of daily living and home exercises. When seen, there was cervical and lumbar paraspinal muscle tenderness with positive Spurling's testing. There was lumbar facet and left sacroiliac joint tenderness. There was decreased upper and lower extremity sensation and decreased left lower extremity strength. Medications include Percocet being prescribed at a total MED (morphine equivalent dose) of 60 mg per day. Restoril and Robaxin are being prescribed on a long-term basis. Restoril (temazepam) is a benzodiazepine used to treat insomnia symptoms. Benzodiazepine medications are not recommended for long-term use. Long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Gradual weaning is recommended for long-term users. Therefore, the ongoing prescribing of Restoril is not medically necessary.