

Case Number:	CM15-0108918		
Date Assigned:	06/15/2015	Date of Injury:	05/26/2003
Decision Date:	07/15/2015	UR Denial Date:	05/27/2015
Priority:	Standard	Application Received:	06/05/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 78 year old female, who sustained an industrial injury on May 26, 2003, incurring low back, right ankle, ribs and neck injuries after a fall from a ladder. She was diagnosed with rib fracture, thoracic and lumbar compression fractures and coccyx fracture. Treatment included physical therapy, anti-inflammatory drugs, antidepressants, heat patches, topical analgesic patches, pain medications, home muscle stimulator and work restrictions. Lumbar Magnetic Resonance Imaging revealed a coccyx fracture and lumbar compression fracture. Currently, the injured worker complained of chronic back, coccyx and neck pain increased with any sort of lifting, pushing, pulling or bending, walking, sitting or climbing stairs. She complained of persistent depression and anxiety secondary to the chronic discomfort and pain. The treatment plan that was requested for authorization included prescriptions for Trazadone and Robaxin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 100 mg #30: 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), mental illness and stress.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Schwartz, T., et al. (2004). "A comparison of the effectiveness of two hypnotic agents for the treatment of insomnia." Int J Psychiatr Nurs Res 10(1): 1146-1150.

Decision rationale: There is no clear evidence that the patient was diagnosed with major depression requiring Trazodone. There is no formal psychiatric evaluation documenting the diagnosis of depression requiring treatment with Trazodone. In addition, there is no documentation of failure of first line treatments for insomnia and depression. Therefore, the request for Trazodone 100MG #30 is not medically necessary.

Robaxin 500 mg #60: Upheld

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

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

Decision rationale: According to MTUS guidelines, Robaxin, a non sedating muscle relaxants, is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic spasm and pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient in this case does not have clear recent evidence of spasm and the prolonged use of Robaxin is not justified. There is no clear documentation of the efficacy of previous use of Robaxin. Therefore, the request of Robaxin 500mg #60 is not medically necessary.