

Case Number:	CM15-0016684		
Date Assigned:	02/05/2015	Date of Injury:	10/26/1999
Decision Date:	03/30/2015	UR Denial Date:	01/21/2015
Priority:	Standard	Application Received:	01/29/2015

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: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 60-year-old female who reported an injury on 10/26/1999. The mechanism of injury was not provided. The diagnoses included a disc bulge at C5-6, right shoulder supraspinatus tendon tear, degenerative changes to the anterior labrum of the right shoulder, right de Quervain's tenosynovitis, and fibromyalgia. The documentation of 08/25/2014 revealed the injured worker had complaints of neck pain and headaches. The injured worker was requesting medication refills. The physical examination revealed the injured worker had painful range of motion with the neck. There was tenderness in the suboccipital triangle to the right and left. There was evidence of muscle spasms in the cervical spine. The treatment plan included Klonopin 1 mg by mouth twice a day for severe spasms and anxiety, Vicodin 5/500 mg 1 by mouth 3 times a day as needed, Prozac 40 mg 1 by mouth daily, Robaxin 500 mg 1 by mouth twice a day for spasms, and Motrin 800 mg 1 by mouth 3 times a day as needed for pain, Prilosec 20 mg 1 by mouth daily for GERD related to medications, and Zofran 4 mg 1 by mouth daily for nausea.

IMR ISSUES, DECISIONS AND RATIONALES

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

Robaxin 500mg #60 x 5 refills: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants for the short term relief of low back pain. Their use is recommended for less than 3 weeks. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documentation of objective functional benefit. There was a lack of documentation indicating a necessity for 5 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Robaxin 500mg #60 x 5 refills is not medically necessary.

Zofran 4mg #30 x 5 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Antiemetics

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

Decision rationale: The Official Disability Guidelines indicate that antiemetics are not recommended for the treatment of nausea and vomiting secondary to opioid use. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for nausea. However, the specific rationale was not provided, nor was the efficacy. There was a lack of documentation indicating a necessity for 5 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Zofran 4mg #30 x 5 refills is not medically necessary.