MAXIMUS Federal Services

Case Number:	CM15-0121735		
Date Assigned:	07/02/2015	Date of Injury:	10/23/2009
Decision Date:	07/31/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	06/23/2015

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, Indiana, New York
Certification(s)/Specialty: Internal 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 51 year old female, who sustained an industrial injury on 10/23/2009. Diagnoses include chronic pain syndrome, lumbosacral spondylosis without myelopathy, adjustment disorder with mixed anxiety and depressed mood, persistent disorder of initiating or maintaining sleep, asthma, sacroiliitis, and post laminectomy syndrome, lumbar region. Treatment to date has comprised of surgical intervention (L5-S1 fusion) and conservative care including diagnostics, injections, ice, rest, and medications that have included Tramadol, morphine, Gralise and Benazepril. Per the Primary Treating Physician's Progress Report dated 3/09/2015, the injured worker reported pain in the right low back over the sacroiliac joint area and pain/spasms/cramping in the right posterior leg. Physical examination revealed flattening of the normal lumbar lordosis. There was tenderness in the right lower lumbar area. Gensler's Faber's and compression test were positive. The plan of care included medications and authorization was requested for Tramadol 50mg #120 and Methocarbamol 500mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription for Methocarbamol 500mg #90 with 1 refill: 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 Muscle relaxants Page(s): 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Muscle relaxants.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Methocarbamol 500mg #90 with one refill is not medically necessary. Muscle relaxants are recommended as a second line option short-term (less than two weeks) of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time and prolonged use may lead to dependence. In this case, the injured worker's working diagnoses are chronic pain syndrome; lumbosacral spondylosis without myelopathy; adjustment disorder with mixed anxiety and depressed mood; persistent disorder of initiating or maintaining sleep; asthma unspecified; sacroiliitis NEC; and post laminectomy syndrome lumbar region. Subjectively, the documentation indicates the injured worker had been prescribed Flexeril for an indeterminate amount of time back in 2010. There was no objective functional improvement with respect to Flexeril. The injured worker had a recent (undated) emergency department visit. Nonsteroidal anti-inflammatory drugs and Methocarbamol were prescribed and were helpful. The injured worker's workup has included epidural steroid injections, facet joint injections and physical therapy. The treating provider prescribed Methocarbamol 500 mg three times daily with one refill. Muscle relaxants recommended for short-term (less than two weeks) of acute low back pain or short-term treatment of an acute exacerbation in chronic low back pain. The treating provider exceeded the recommended guidelines by prescribing one month plus 1 refill. There is no documentation in the medical record indicating objective functional improvement to support ongoing Methocarbamol. There is no lumbar muscle spasm documented on physical examination. There is no documentation of acute low back pain or any acute exacerbation of chronic low back pain. The injured worker has continued complaints of chronic low back pain. Consequently, absent clinical documentation of acute low back pain or an acute exacerbation of chronic low back pain and treatment continued in excess of the recommended guidelines (less than two weeks), Methocarbamol 500mg #90 with one refill is not medically necessary.