

Case Number:	CM14-0140430		
Date Assigned:	09/10/2014	Date of Injury:	11/07/2011
Decision Date:	10/15/2014	UR Denial Date:	08/21/2014
Priority:	Standard	Application Received:	08/29/2014

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 & Rehabilitation and is licensed to practice in Georgia. 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 patient is a 54 year old female who sustained an injury to her lower back while carrying televisions at work on 11/07/2011. Prior medication history included Robaxin, atenolol, Celexa, and Seroquel. Prior treatment history has included caudal epidural steroid injection on 02/21/2014. Diagnostic studies reviewed include MRI of the lumbar spine dated 01/20/2014 revealed 9 mm disc protrusion at L4-5 causing moderate to severe midline compression of the thecal sac; a 2 mm posterior disc bulge at L3-4 with mild to moderate left and mild right L4-5 facet hypertrophy. Progress report dated 07/22/2014 states the patient presented with complaints of low back pain and left lower extremity pain. She rated her pain as 6/10 with medications and 7/10 without medications. On exam, the lumbar spine revealed restricted range of motion with flexion, extension, lateral rotation to the left and lateral rotation to the right. There was paravertebral muscle tenderness on both sides. Straight leg raise is positive on the left side in sitting at 50 degrees. The patient is diagnosed with mild to moderate left and mild right L4-5 facet hypertrophy. Prior utilization review dated 08/21/2014 states the request for Ambien 10mg Quantity Requested: 30.00; Robaxin 750mg Quantity Requested: 360.00 is denied and weaning is indicated; Percocet 10/325m Quantity Requested: 180.00 is modified to a quantity of 120.00; Acupuncture (Sessions) Quantity Requested: 18.00 is modified for 6 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN 10MG QUANTITY REQUESTED: 30.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

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

Decision rationale: CA MTUS guidelines do not address the issue in dispute and hence ODG have been consulted. As per ODG, Zolpidem (Ambien) is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain." Additionally, it is unclear from the records for how long he has been prescribed this medication since guidelines only recommend short-term use for 2-6 weeks. Furthermore, there is no documentation of any significant improvement in sleep with prior use. Thus, the request is not medically necessary.

ROBAXIN 750MG QUANTITY REQUESTED: 360.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for chronic pain), Methocarbamol (Robaxin, Relaxin, generic available Pag.

Decision rationale: According to the CA MTUS guidelines, Methocarbamol (Robaxin) is recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. In the absence of documented muscle spasm on physical examination, the request is not medically necessary according to the guidelines. However, in most LBP cases, it shows no benefit beyond NSAIDs in pain and overall improvement. In this case the medical records do not document the presence of substantial muscle spasm refractory to first line treatments. The medical records do not demonstrate the patient presented with exacerbation unresponsive to first-line interventions. There is no documentation of any significant improvement with prior use. Chronic use of muscle relaxants is not recommended by the guidelines, thus the request is not medically necessary.

PERCOCET 10/325M QUANTITY REQUESTED: 180.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 92.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Page(s): 76-96.

Decision rationale: According to CA MTUS guidelines, Percocet (Oxycodone & Acetaminophen) as a short-acting Opioid is recommended for intermittent or breakthrough pain. Guidelines indicate "four domains have been proposed as most relevant for ongoing monitoring

of chronic pain patients on opioids; pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. The medical records do not establish failure of non-opioid analgesics, and there is no mention of ongoing attempts with non-pharmacologic means of pain management. There is little to no documentation of any significant improvement in pain level (i.e. VAS) or function with prior use to demonstrate the efficacy of this medication. There is no evidence of urine drug test in order to monitor compliance. The medical documents do not support continuation of opioid pain management. Therefore, the medical necessity for Percocet has not been established based on guidelines and lack of documentation. Therefore the request is not medically necessary.

ACUPUNCTURE (SESSIONS) QUANTITY REQUESTED: 18.00: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Acupuncture

Decision rationale: "Acupuncture" is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The medical records do not establish the patient is a candidate for Acupuncture treatment, as the above criteria are not met. Also, the requested number of sessions is not supported by the guidelines. Therefore, the medical necessity of Acupuncture is not established and is not medically necessary.