

Case Number:	CM13-0064234		
Date Assigned:	01/03/2014	Date of Injury:	10/26/1993
Decision Date:	04/15/2014	UR Denial Date:	12/03/2013
Priority:	Standard	Application Received:	12/11/2013

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 63-year-old male who reported an injury on 10/26/1993. The mechanism of injury was not provided for review. The patient developed chronic low back pain rated at an 8/10 that was managed with medications. The patient was monitored for aberrant behavior with urine drug screens. The patient's most recent medication schedule included naproxen 500 mg, Soma 350 mg, Oxycodone 15 mg, OxyContin 60 mg, Colace 250 mg, Zanaflex 4 mg, and aspirin 325 mg. The patient's most recent physical findings included limited range of motion of the lumbar spine with positive Gaenslen's test and positive Faber's test, with tenderness noted over the posterior iliac spine on the left side and trigger points with radiating pain of the lumbar paraspinal musculature. The patient's diagnoses included sacroiliac pain and chronic back pain. The patient's treatment plan included initiation of Flexeril as Soma had been denied, participation in a home exercise program, and trigger point injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLEXERIL 10MG #45, 1 REFILL: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines recommends short durations of treatment for muscle relaxants not to exceed more than 2 weeks to 3 weeks. The clinical documentation does indicate that the patient has not previously used Flexeril as a muscle relaxant. Therefore, a trial of this medication may be indicated. However, the requested 45 pills with 1 refill exceeds the recommended treatment duration. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. The request for Flexeril 10mg #45 refill 1 is not medically necessary and appropriate.

OXYCODONE HCl 15MG #120 1 REFILL: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines recommends opioids in the management of chronic pain be supported by documentation of a quantitative assessment of pain relief, evidence of functional benefit, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient is regularly monitored for aberrant behavior with urine drug screens and CURES reports. However, the clinical documentation submitted for review fails to provide a quantitative assessment to support pain relief with medication usage. Additionally, there is no increased functional benefit specifically identified within the documentation. The request for Oxycodone HCl 15mg #120, 1 refill is not medically necessary and appropriate.

OXYCONTIN 60MG #90, 1 REFILL: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines recommends opioids in the management of chronic pain be supported by documentation of a quantitative assessment of pain relief, evidence of functional benefit, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does provide evidence that the patient is regularly monitored for aberrant behavior with urine drug screens and CURES reports. However, the clinical documentation submitted for review fails to provide a quantitative assessment to support pain relief with medication usage. Additionally, there is no increased functional benefit specifically identified within the

documentation. The request for OxyContin 60mg #90, 1 refill is not medically necessary and appropriate.

SOMA 350MG #90, 1 REFILL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines recommends muscle relaxants be used for short durations of treatment of up to 2 weeks to 3 weeks for the management of moderate to severe pain and muscle spasming. The clinical documentation submitted for review does indicate that the patient has been on this medication in excess of 6 months. Therefore, continued use would not be supported. The request for Soma 350mg #90, 1 refill is not medically necessary and appropriate.