

Case Number:	CM13-0071905		
Date Assigned:	01/08/2014	Date of Injury:	05/19/2001
Decision Date:	04/30/2014	UR Denial Date:	12/11/2013
Priority:	Standard	Application Received:	12/30/2013

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Okalahoma. 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 59-year-old male who reported an injury on 05/19/2001. The mechanism of injury was not provided for review. The patient reportedly injured their left knee, right knee, and suffered emotional distress. The patient's most recent clinical evaluation documented that the patient had failed to respond to multiple modalities to include surgical intervention, knee injections, physical therapy, and opioid and non opioid medications. Physical examination revealed crepitus with bilateral knee joint palpitation, restricted range of motion of the lumbar spine secondary to pain, tenderness to palpation over the L4-5 lumbar facet joints and decreased sensation to light touch in the medial calves bilaterally. The patient's diagnoses included chronic right knee pain status post bilateral knee surgeries, opioid tolerance, chronic pain syndrome, axial low back pain, myofascial pain syndrome, lumbar facet pain, and lumbar spondylosis without myelopathy. It was also noted that the patient underwent a functional restoration evaluation and treatment goals were provided. A request was made for continuation of medications and participation in a functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLEXERIL 10 MG #90: Upheld

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

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

Decision rationale: The requested Flexeril 10 mg #90 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of muscle relaxants be limited to short courses of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The request is for 90 tablets. This exceeds the treatment duration recommended by California Medical Treatment Utilization Schedule. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested Flexeril 10 mg #90 is not medically necessary or appropriate.

HYDROCODONE 10/325 #120: Upheld

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

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

Decision rationale: The requested hydrocodone 10/325 mg #120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of opioids be supported by documentation of functional benefit, a quantitative assessment of pain relief, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does not provide any evidence that the patient is monitored for aberrant behavior. Additionally, there is no documentation that the patient receives any functional benefit or symptom relief as a result of the patient's medication usage. Therefore, ongoing use of opioids would not be supported by guideline recommendations. As such, the requested hydrocodone 10/325 mg #120 is not medically necessary or appropriate.

ZOLPIDEM 5 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)

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

Decision rationale: The requested Zolpidem 5 mg #30 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address the use of this medication. Official Disability Guidelines recommend the use of Zolpidem for short durations of treatment not to exceed 2 to 6 weeks. The clinical documentation does indicate that the patient has been prescribed this medication since at least 2010. This exceeds the recommendations made by California Medical Treatment Utilization Schedule. There are no exceptional factors noted to

support extending treatment beyond guideline recommendations. As such, the requested Zolpidem 5 mg #30 is not medically necessary or appropriate.

FUNCTIONAL RESTORATION PROGRAM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Management Programs Page(s): 30.

Decision rationale: The requested functional restoration program is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends patients who have been appropriately evaluated for a functional restoration program attend a 2-week trial to determine the efficacy of the program for the patient. The request does not include a duration or frequency of treatment. Therefore, the appropriateness of the request cannot be determined. As such, the requested functional restoration program is not medically necessary or appropriate.