

Case Number:	CM14-0004257		
Date Assigned:	02/05/2014	Date of Injury:	06/08/2007
Decision Date:	06/20/2014	UR Denial Date:	12/11/2013
Priority:	Standard	Application Received:	01/10/2014

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 Internal Medicine, and is licensed to practice in California. 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 injured worker is a 47 year old male with an injury reported on 06/08/2007. The mechanism of injury was not provided within the clinical notes. The clinical note dated 04/17/2011, reported that the injured worker complained of low back pain associated with limited range of motion of his lumbar spine and right leg. Per examination of musculoskeletal there was limited range of motion of the lumbar spine and bilateral positive straight leg raise. The injured worker's diagnoses included appendectomy in 1986, two level laminectomy was performed posteriorly at L4-5 and L5-S1 in 1989, coronary angioplasty in 2000, bilateral vasectomy in 2004, and a decompression at L4-5, L5-S1 without fusion on 12/11/2007. The request for authorization was submitted on 01/10/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLEXERIL 5MG #120 BETWEEN 11/6/2013 AND 3/9/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, CYCLOBENZAPRINE (FLEXERIL),

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine (Flexeril), Page 41..

Decision rationale: The request for Flexeril 5mg #120 between 11/06/2013 and 03/09/2014 is is not medically necessary. The clinical note dated 04/17/2011, reported that the injured worker complained of low back pain associated with limited range of motion of his lumbar spine and right leg. According to the California MTUS guidelines on (flexeril) recommended as an option, using a short course of therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. There is a lack of recent clinical documentation, the only clinical note provided was an urology note dated 04/17/2011. Per urology note, the provider did not indicate rationale for Flexeril. There is a lack of clinical documentation indicating the injured worker voiced need of muscle relaxer. There is also a lack of clinical information provided on effectiveness of the injured worker's current prescribed medications. Therefore, the request for flexeril 5mg #120 between 11/06/2013 and 03/09/2014 is is not medically necessary.

PERCOCET 10/325MG #120 BETWEEN 12/9/2013 AND 3/9/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, May 2009, Cyclobenzapri.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Specific Drug List, Page(s): 92.

Decision rationale: The request for Percocet 10/325mg #120 between 12/09/2013 and 03/09/2014 is is not medically necessary. The clinical note dated 04/17/2011, reported that the injured worker complained of low back pain associated with limited range of motion of his lumbar spine and right leg. According to the California MTUS guidelines for oxycodone dosage is based the content and should be administered every 4 to 6 hours as needed for pain. Initially 2.5 to 5 mg PO every 4 to 6 hours prn. Maximum daily dose is based on acetaminophen content (Maximum 4000mg/day). For more severe pain the dose (based on oxycodone) is 10-30mg every 4 to 6 hours prn pain. Dose should be reduced in patients with severe liver disease. There is a lack of recent clinical documentation, the only clinical note provided was dated 04/17/2011. The clinical information provided listed Percocet as a prescribed medication for the injured worker; however, the note lacked the medication dose, the effectiveness of the injured worker's pain, and the frequency use. Therefore, the request for Percocet 10/325mg #120 between 12/09/2013 and 03/09/2014 is is not medically necessary.