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| Case Number: | CM14-0103463 | | |
| Date Assigned: | 09/16/2014 | Date of Injury: | 01/18/2006 |
| Decision Date: | 10/15/2014 | UR Denial Date: | 06/30/2014 |
| Priority: | Standard | Application Received: | 07/03/2014 |

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 Occupational 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:

According to the records made available for review, this is a 63-year-old female with a 1/18/06 date of injury. At the time (6/30/14) of the Decision for Flexeril 5mg #90, Oxycodone HCL 30mg #90, and 12 Lead EKG to evaluate the QT interval based on the prescription of opioids, there is documentation of subjective (ongoing moderate to severe neck and shoulder pain radiating to the back and down the left arm with numbness and tingling) and objective (trigger points palpated in the upper trapezius, lower trapezius, splenius capitis and quadratus lumborum, decreased strength in the shoulders and elbows, paresthesias in the digits of the hands and medial legs, decreased reflexes of the upper and lower extremities, positive Spurling's test, and positive sacroiliac joint compression test) findings, current diagnoses (chronic pain syndrome, cervical radiculopathy, and lumbosacral neuritis/radiculitis), and treatment to date (ongoing therapy with Flexeril and Oxycodone since at least 2/20/14 with 40-60% pain relief and increased functioning). In addition, medical reports identify an opioid agreement. Regarding Flexeril 5mg #90, there is no documentation of acute exacerbation of chronic pain and short-term (less than two weeks) treatment. Regarding Oxycodone HCL 30mg #90, there is no documentation that a continuous, around-the-clock analgesic is needed for an extended period of time. Regarding 12 Lead EKG to evaluate the QT interval based on the prescription of opioids, there is no documentation of a condition/diagnosis (with supportive clinical findings) for which an EKG is indicated (effects and side effects of pharmacotherapy).

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic drugs Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN) Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle relaxant. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended for short-term (less than two weeks) treatment. Within the medical information available for review, there is documentation of diagnoses of chronic pain syndrome, cervical radiculopathy, and lumbosacral neuritis/radiculitis. In addition, there is documentation of chronic pain. Furthermore, given documentation of ongoing treatment with Flexeril with 40-60% pain relief and increased functioning, there is documentation of functional benefit or improvement as an increase in activity tolerance as a result of use of Flexeril. However, there is no documentation of acute exacerbation of chronic pain. In addition, given documentation of ongoing treatment with Flexeril since at least 2/20/14, there is no documentation of short-term (less than two weeks) treatment. Therefore, based on guidelines and a review of the evidence, the request for Flexeril 5mg #90 is not medically necessary.

Oxycodone HCL 30mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS; OXYCODONE Page(s): 74-80; 92. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time, as criteria necessary to support the medical necessity of Oxycodone. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to

support the medical necessity of Oxycodone. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of chronic pain syndrome, cervical radiculopathy, and lumbosacral neuritis/radiculitis. In addition, there is documentation of moderate to severe pain. Furthermore, given documentation of an opioid agreement, there is documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Lastly, given documentation of ongoing treatment with Oxycodone with 40-60% pain relief and increased functioning, there is documentation of functional benefit or improvement as an increase in activity tolerance as a result of use of Oxycodone. However, despite documentation of ongoing pain, there is no (clear) documentation that a continuous, around-the-clock analgesic is needed for an extended period of time. Therefore, based on guidelines and a review of the evidence, the request for Oxycodone HCL 30mg #90 is not medically necessary.

12 Lead EKG to evaluate the QT interval based on the prescription of opioids: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: (<http://emedicine.medscape.com/article/1894014-overview>)

Decision rationale: MTUS and ODG do not address this issue. Medical Treatment Guideline identifies documentation of a condition/diagnosis (with supportive clinical findings) for which an EKG is indicated (such as: disorders of cardiac rhythm; evaluation of syncope; evaluation of patients with implanted defibrillators and pacemakers; detection of myocardial injury or ischemic coronary disease; the presence of prior infarction; evaluation of metabolic disorders; effects and side effects of pharmacotherapy; and/or the evaluation of primary and secondary cardiomyopathic processes), as criteria necessary to support the medical necessity of EKG. Within the medical information available for review, there is documentation of diagnoses of chronic pain syndrome, cervical radiculopathy, and lumbosacral neuritis/radiculitis. However, despite documentation of a request for EKG to evaluate the QT interval based on the prescription of opioids, and given no documentation of supportive subjective/objective findings consistent with cardiac disorders/disorders of the QT interval, there is no documentation of a condition/diagnosis (with supportive clinical findings) for which an EKG is indicated (effects and side effects of pharmacotherapy). Therefore, based on guidelines and a review of the evidence, the request for 12 Lead EKG to evaluate the QT interval based on the prescription of opioids is not medically necessary.