

Case Number:	CM14-0107905		
Date Assigned:	08/01/2014	Date of Injury:	07/19/2013
Decision Date:	09/11/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/11/2014

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 and Rehabilitation and is licensed to practice in Texas and Oklahoma. . 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 41-year-old male who reported an injury on 07/19/2013 due to an unknown mechanism. Diagnoses were ulnar impaction syndrome, medial epicondylitis on the left, element of stress, depression, insomnia, enlargement of liver (seems to be fatty liver) with some elevated blood tests recently. Past treatments have been for an elbow sleeve, the use of a TENS unit and physical therapy. Diagnostic studies reported were MRI of the wrist, and EMG. Surgical history was not reported. The injured worker had a physical examination on 07/10/2014 with complaints of left wrist and left elbow pain. He also complained of sleep issues and elements of depression. Examination of the left elbow revealed extension was to 180 degrees and flexion was to 160 degrees. Range of motion of the left wrist was satisfactory. There was crepitation noted. The injured worker stated his pain was a 2/10 with medications. He also reported the pain level was a 5/10 to 6/10 at rest and a 10/10 with movement and tasking. Medications were Flexeril, gabapentin, and Oxycontin. The rationale was the injured worker was recommended to have surgery for the purpose of improving his functionality. Treatment plan was to continue medications as directed and request authorization for pain management. The request for authorization was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

OxyContin 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Oxycontin; Ongoing Management Page(s): 75, 78.

Decision rationale: The request for Oxycontin 10mg #60 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend long acting opioids (Oxycontin) for around the clock pain relief and indicated not for as needed use. The guidelines also recommend that there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. Although the injured worker has reported pain relief from the medication, the provider did not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Flexeril 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

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

Decision rationale: The request for Flexeril 10mg #60 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for the short-term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review provides evidence that the patient has been on this medication for an extended duration of time and there is a lack of documentation of objective improvement. Therefore, continued use of this medication would not be supported. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.