

Case Number:	CM14-0016371		
Date Assigned:	04/11/2014	Date of Injury:	01/31/2012
Decision Date:	05/28/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	02/10/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine 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 57-year-old female who reported an injury on 01/31/2012, due to a slip and fall that reportedly caused injury to the right knee. The injured worker's treatment history included physical therapy and medications. The injured worker has also received epidural steroid injections to the cervical spine. Medication schedule since 08/2013 has included Oxycodone, Tramadol, Cyclobenzaprine, and Trazodone. Evaluation dated 12/30/2013, documented that the patient had continued neck pain radiating into the left elbow, with right knee pain described as 9/10 without medications, reduced to a 6/10 to 7/10 with medications. Physical findings included restricted cervical spine range of motion; decreased left interossei and finger flexors rated at a 4/5, and assisted ambulation with crutches. Diagnoses included chronic neck pain, cervical degenerative disc disease, cervical spondylosis, left cervical radiculopathy, left elbow pain, right knee pain, laxity of the right anterior cruciate ligament, and right cuboid fracture. Treatment plan included right knee surgery on 01/16/2014 and continued use of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

DESYREL 50MG #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Insomnia Treatment.

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, Insomnia Treatments.

Decision rationale: The California Medical Treatment Utilization Schedule does not address the medication in this capacity. Official Disability Guidelines recommend the use of trazodone as a sleep aid for short durations. As the injured worker has been on this medication for an extended duration, continued use would not be supported. Additionally, the most recent clinical documentation did not provide an adequate assessment of the injured worker's sleep hygiene to support continued insomnia treatment. Also, the request as it is submitted does not clearly identify a frequency of treatment. The request for Desyrel 50 mg #60 is not medically necessary and appropriate.

FLEXERIL 7.5MG #60: Upheld

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

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

Decision rationale: California MTUS Chronic Pain Medical Treatment Guidelines does not support the use of muscle relaxants in the management of chronic pain. It is recommended that these medications are used for short durations of treatment, not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. As the injured worker has been on this medication for a duration that exceeds recommendations, continued use would not be supported. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. The request for Flexeril 67.5 mg #60 is not medically necessary and appropriate.

ROXICODONE 15MG #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria For Use Of Opioids.

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

Decision rationale: California MTUS Chronic Pain Medical Treatment Guidelines recommends continued use of opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, evidence that the injured worker is

monitored for aberrant behavior, and documentation of managed side effects. The clinical documentation submitted for review does indicate that the injured worker has pain relief from the current medication schedule. However, there is no documentation that the injured worker is regularly monitored for aberrant behavior. Additionally, there is no documentation of significant functional benefit related to medication usage to support continued use of this medication. Also, the request as it is submitted does not clearly define a frequency of treatment. The request for Roxycodone 15 mg #180 is not medically necessary and appropriate.