

Case Number:	CM14-0017957		
Date Assigned:	04/16/2014	Date of Injury:	05/08/2007
Decision Date:	06/03/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/12/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

Patient is an employee of [REDACTED] who filed a claim of low back pain s/p post lumbar fusion, L3-4 and L4-L5 associated with industrial injury date of 05/08/2007. Treatment to date includes x-ray of lumbar spine which revealed both anterior and posterior lumbar interbody fusion. MRI of lumbar spine showed disc protrusion in L3-L4 and L4-5. Patient underwent laminectomy discectomy of L3-4 and L4-5 and total laminectomy, L4-5, L3-4 with evacuation of hematoma. Claimant also had physical therapy sessions. Medications include Relafen, Flexeril, Tylenol which was prescribed in 2007, Tenoretic, Enalapril, Naproxen prescribed in 2008, Omeprazole, Naprosyn 550 mg, Norco 10/325, Ambien 10 mg, Capsaicin/Salicylate lotion, Ultram, Prilosec prescribed in 2009, Tramadol 50 mg, Soma 350 mg, Anaprox 550mg, Buprion 150 mg, Hydrocodone, Viagra prescribed in 2010, Cyclobenzaprine 10mg and Oxycodone prescribed on 2013. Medical records from 2007 to 2014 were reviewed which revealed symptomatic lower back pain with radiating symptoms down the right leg along with a foot drop. Patient continued to utilize crutches for support. His pain scale ranges from 4-6/10. Physical examination revealed moderate tenderness to palpation over L4-5 and L5-S1 region. Range of motion of the lumbar spine was limited approximately 40 to 50% of the normal range. Manual muscle testing of the lower extremity revealed diminished muscle strength in bilateral hip flexion, 4/5 in right knee flexion and extension and 4/5 in right ankle dorsiflexion and plantar flexion. Straight leg raising test was positive in the right lower extremity at a 45 degrees angle in a sitting position. Utilization review from January 1, 2014 denied the request of Cyclobenzaprine 10mg, #60/30 days because according to CA MTUS Cyclobenzaprine is only recommended as a short course of therapy in the management of back pain. Oxycodone 5/325mg, #90/30 was also denied because the 4 A's need to be addressed/documentated in the use of oxycodone and urine drug screen results were not discussed by the physician in the medical records reviewed.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRESCRIPTION FOR CYCLOBENZAPRINE 10MG #60/30 DAYS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Section, Page(s): 41-42, 64-65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

Decision rationale: According to CA MTUS Chronic Pain Medical Treatment Guidelines stated on page 64, Cyclobenzaprine is recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. In this case, patient has been prescribed since 02/2013. However, no significant improvement noted in the patient. Since Cyclobenzaprine is not recommended for chronic use and no significant improvement noted in the patient, the request for Cyclobenzaprine 10mg #60/30 is not medically necessary.

PRESCRIPTION FOR OXYCODONE 5/325MG #90/30DAY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

Decision rationale: According to CA MTUS Chronic Pain Medical Treatment Guidelines stated on pages 79-81, the recommended maximum use of opioids is only 3 months provided that there's pain relief, documented improvement in functional status. If patient does not improve on the said duration of use, re-assessment is suggested. In this case, patient was prescribed Oxycodone since 2013 with no significant improvement in pain and functional status. Therefore the request for dispensing Oxycodone 5/325mg #90/30 is not medically necessary.