

<b>Case Number:</b>	CM14-0156790		
<b>Date Assigned:</b>	10/08/2014	<b>Date of Injury:</b>	11/10/2009
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	09/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2014

### 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 & Rehabilitation, has a subspecialty in Spinal Cord Injury and is licensed to practice in New York. 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 48-year-old male who reported an injury on 11/10/2009. The mechanism of injury was not provided. The injured worker has a diagnosis of cervical strain. The past medical treatment included medications and surgery. Diagnostic testing was not provided. The injured worker underwent a right subacromial decompression. The injured worker complained of increased pain to the right shoulder radiating down the arm, complaining of clicking in the elbow on 08/29/2014. The injured worker stated increased soreness and had been unable to sleep. The physical examination revealed pain with range of motion and decreased range of motion. The examination revealed a positive Hawkins, positive spasms, positive impingement, and positive stiffness. Medications were not provided. The treatment plan was for Flexeril 10 mg #90 and OxyContin 20 mg #60. The rationale for the request was not submitted. The Request for Authorization form was submitted on 09/02/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexeril 10mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Page(s): 63, 41, & 74-82.

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

**Decision rationale:** The injured worker complained of increased pain to the right shoulder radiating down the arm, complaining of clicking in the elbow on 08/29/2014. The California MTUS Guidelines state that Flexeril is recommended for a short course of therapy. This medication is not recommended to be used for longer than 2-3 weeks. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. The guidelines state flexeril is not recommend for chronic pain or to be used for longer than 2-3 weeks. There is lack of documentation stating the length of time the injured worker has been prescribed the requested medication. There is a lack of evidence of muscle spasms documented upon physical examination. There is a lack of documentation of the physician's rationale for prescribing a muscle relaxant. The frequency of the requested medication was not provided. Therefore the request for Flexeril 10mg #30 is not medically necessary.

**Oxycontin 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

**Decision rationale:** The California MTUS guidelines recommend ongoing review with documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain, the least reported pain over the period since last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The guidelines also recommend providers assess for side effects and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. There is a lack of documentation indicating the patient has improved functioning and pain with the use of the medication. There is a lack of documentation of a measured assessment of the injured worker's pain level. There is a lack of documentation indicating urine drug screening has been performed. Additionally, the request does not indicate the frequency at which the medication is prescribed. Therefore, the request for Oxycontin 20mg #60 is not medically necessary.