

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0171549 | | |
| Date Assigned: | 11/13/2014 | Date of Injury: | 07/02/2002 |
| Decision Date: | 12/31/2014 | UR Denial Date: | 09/23/2014 |
| Priority: | Standard | Application Received: | 10/16/2014 |

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 and is licensed to practice in Tennessee, North Carolina and Georgia. 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 07/02/2002. The mechanism of injury was due to her moving a box and another person moving another box causing her to jerk down, feeling a pop in her back. The injured worker has diagnoses of lumbar radiculitis, myofascial syndrome, chronic pain syndrome, prescription narcotic dependence, failed back syndrome, and chronic pain related depression. Past medical treatment consists of surgery, physical therapy, psychological evaluations and medication therapy. Medications include Gabadone, Percura, Trepadone, Suboxone and Flexeril. No urinalysis or drug screens are submitted for review. On 10/21/2014, the injured worker complained of low back pain. It was noted on physical examination that the injured worker rated the pain at a 7/10 and a 10/10 without medications. No objective findings on the injured worker's low back were documented in the progress note. The medical treatment plan is for the injured worker to continue with medication therapy. The provider feels that the medications help take the edge off of the pain and continue to provide pain relief and improve function. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Suboxone #45: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine (Suboxone) Page(s): 26-27.

Decision rationale: The request for Suboxone #45 is not medically necessary. According to the MTUS Guideline criteria, Suboxone is recommended for the treatment of opioid addiction. It is also recommended as an option for chronic pain, especially after detoxification in patients who have a history of opioid addiction. Guidelines also state that there should be clear documentation of compliance with the Drug Addiction Treatment Act of 2000. There should be assessments submitted for review indicating the efficacy of the medication. The submitted documentation dated 10/2014 failed to indicate the efficacy of the medication nor did it indicate that it was helping with any functional deficits. It was documented that the Suboxone helped take the edge off the pain. However, there was no pertinent evidence or indication of what pain levels were before, during, or after medication administration. Additionally, there was no urinalysis or drug screen submitted for review showing that the injured worker was complying with the Drug Addiction Treatment Act of 2000. Furthermore, the request as submitted did not indicate a frequency or duration of the medication. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.

Flexeril 10mg #90: 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 for pain Page(s): 63.

Decision rationale: The request for Flexeril 10mg #90 is not medically necessary. The California MTUS Guidelines recommend Flexeril is an option for a short term course of therapy. The greatest effect of this medication is in the first 4 days of treatment, suggesting that a shorter course may be better. Treatments should be brief. The request as submitted is for Flexeril 10 mg with a quantity of 90, exceeding the recommended guideline criteria for short term therapy. Additionally, there was no rationale submitted for review to warrant the continuation of the medication. Furthermore, there were no objective findings documented in the report. There was also no mention of the injured worker having any complaints of muscle spasm. Given the above, the injured worker is not within MTUS guideline criteria. As such, the request is not medically necessary.