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| Case Number: | CM14-0023782 | | |
| Date Assigned: | 06/11/2014 | Date of Injury: | 05/01/2010 |
| Decision Date: | 07/15/2014 | UR Denial Date: | 01/29/2014 |
| Priority: | Standard | Application Received: | 02/25/2014 |

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 Family Medicine and is licensed to practice in Arizona. 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 patient is a 31-year-old female with a date of injury on 05/01/2010. The patient has been treated for ongoing symptoms related to the low back. The diagnoses include discogenic lumbar condition with facet inflammation, depression and anxiety. Subjective complaints are of low back pain, muscle spasms, stiffness and tightness. A physical exam shows lumbar paraspinal tenderness, and decreased range of motion, and negative straight leg raise test. A lumbar MRI from 06/20/2012 shows a disc bulge at L5-S1 with foraminal extension. The electrodiagnostic studies from 06/27/12 were normal. The medications include Norco 10/325, Paxil, Motrin, Flexeril, Wellbutrin, Terocin, Lidopro, and Trazodone. Submitted documentation states that the medications were helpful for the patient's significant back pain and offered functional improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

NORCO 10/325MG #120 (PRESCRIBED 01/15/14): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Pain treatment agreement Page(s): 89.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The patient in question has been on chronic opioid therapy. The Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. For this patient, documentation shows stability on medication, increase functional ability, and no adverse side effects. Furthermore, documentation is present of the MTUS opioid compliance guidelines, including medication monitoring, risk assessment and ongoing efficacy of medication. Therefore, the use of this medication is consistent with guidelines and is medically necessary for this patient.

NORCO 10/325MG #120 (FOR THE NEXT VISIT SCHEDULED ON 02/26/14):

Overtured

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Pain treatment agreement Page(s): 89.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The patient in question has been on chronic opioid therapy. The Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. For this patient, documentation shows stability on medication, increase functional ability, and no adverse side effects. Furthermore, documentation is present of the MTUS opioid compliance guidelines, including medication monitoring, risk assessment and ongoing efficacy of medication. Therefore, the use of this medication is consistent with guidelines and is medically necessary for this patient.

MOTRIN 800MG #60 (FOR THE NEXT SCHEDULED VISIT ON 02/26/14): Overtured

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain-NSAIDs Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

Decision rationale: The Chronic Pain Guidelines recommend non-steroidal anti-inflammatory drugs (NSAIDs) at the lowest effective dose in patients with moderate to severe pain. Furthermore, NSAIDs are recommended as an option for symptomatic relief for back pain. For this patient, moderate pain is present in the back. Therefore, the requested Motrin is consistent with guideline recommendations and is medically necessary.

FLEXERIL 7.5MG #60 (TO BE DISPENSED AT THE NEXT VISIT SCHEDULED ON 02/26/14): 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
Cyclobenzaprine; muscle relaxants (for pain) Page(s): 41-42, 63.

Decision rationale: The Chronic Pain Guidelines indicate that the use of cyclobenzaprine should be used as a short term therapy, and the effects of treatment are modest and may cause adverse affects. This patient had been using a muscle relaxer chronically, which is longer than the recommended course of therapy of two to three (2-3) weeks. There is no evidence in the documentation that suggests the patient experienced improvement with the ongoing use of cyclobenzaprine. Due to the guidelines suggesting that cyclobenzaprine is a short-term therapy and that there is no clear benefit from adding this medication, the requested prescription for cyclobenzaprine is not medically necessary.