

<b>Case Number:</b>	CM14-0029762		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	02/06/2003
<b>Decision Date:</b>	07/16/2014	<b>UR Denial Date:</b>	02/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/07/2014

### 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 has a subspecialty in Pain Medicine 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:

According to the records made available for review, this is a 44-year-old female with a 2/6/03 date of injury. At the time (2/4/14) of the request for authorization for Flexeril 10mg, #45 (with 1 refill); Oxycodone 30mg, #120; and Celexa 20mg, #30 (with 2 refills), there is documentation of subjective (ongoing pain, leg pain more problematic than low back pain) and objective (obese) findings, current diagnoses (lumbago; depressive disorder NOS; insomnia; neuralgia, neuritis, and radiculitis unspecified; arthropathy unspecified, and displacement of intervertebral disc without myelopathy), and treatment to date (medication including Flexeril, Oxycodone, and Celexa for at least 3 months).

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **PRESCRIPTION OF FLEXERIL 10MG, #45 (WITH 1 REFILL): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain).

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that Flexeril is recommended for a short course of therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of lumbago; depressive disorder NOS; insomnia; neuralgia, neuritis, and radiculitis unspecified; arthropathy unspecified, and displacement of intervertebral disc without myelopathy. However, there is no documentation of acute muscle spasm. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services with use of Flexeril. Furthermore, given documentation of records reflecting prescriptions for Flexeril since at least 11/15/13, there is no documentation of the intention to treat over a short course (less than two weeks). Therefore, based on guidelines and a review of the evidence, the request for Flexeril 10mg, #45 (with 1 refill) is not medically necessary.

**PRESCRIPTION OF OXYCODONE 30MG, #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS (SPECIFIC DRUG LIST).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Oxycodone Page(s): 74-80; 92.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time, as criteria necessary to support the medical necessity of Oxycontin. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of Oxycontin. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbago; depressive disorder NOS; insomnia; neuralgia, neuritis, and radiculitis unspecified; arthropathy unspecified, and displacement of intervertebral disc without myelopathy. In addition, there is documentation of treatment with Oxycodone for at least 3 months. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, there is no documentation of functional benefit or improvement

as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services with use of Oxycodone. Therefore, based on guidelines and a review of the evidence, the request for Oxycodone 30mg, #120 is not medically necessary.

**PRESCRIPTION OF CELEXA 20MG, #30 (WITH 2 REFILLS): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SSRI (SELECTIVE SEROTONIN REUPTAKE INHIBITORS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, Antidepressants.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain, as criteria necessary to support the medical necessity of antidepressants. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of depression, as criteria necessary to support the medical necessity of antidepressants. Within the medical information available for review, there is documentation of diagnoses of lumbago; depressive disorder NOS; insomnia; neuralgia, neuritis, and radiculitis unspecified; arthropathy unspecified, and displacement of intervertebral disc without myelopathy. In addition, there is documentation of chronic pain and treatment with Celexa for at least 3 months. However, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services with use of Celexa. Therefore, based on guidelines and a review of the evidence, the request for Celexa 20mg, #30 (with 2 refills) is not medically necessary.