MAXIMUS Federal Services

Case Number:	CM14-0032113		
Date Assigned:	06/20/2014	Date of Injury:	05/01/2001
Decision Date:	07/29/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/13/2014

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 and is licensed to practice 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:

The injured worker is a 62-year-old male who reported an injury on 03/06/2002. The diagnoses included postlaminectomy, myofascial pain, degenerative intervertebral disc, hypercholesterolemia and hypertensive disorder as well as neurogenic pain. Previous treatments include medications, surgery and MRI. Within the clinical note dated 05/13/2014, it was reported that the injured worker complained of tingling and numbness in the right upper extremity. The injured worker complained of severe pain in his neck. He described his left leg pain as aching, throbbing, shooting and stabbing. On the physical examination, the provider noted crepitus upon the injured worker's range of motion of the neck. Also noted was tenderness on palpation of the cervical paraspinal muscles. The injured worker had tenderness along the C5-6 on the right side. He had decreased sensation along the ulnar nerve distribution of the right upper extremity. His grip strength was decreased on the right at 4/5 compared to 5/5 on the left. The provider requested cyclobenzaprine and oxycodone. However, the rationale was not provided for the clinical review. The request for authorization was provided and dated 05/13/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64..

Decision rationale: The request for Cyclobenzaprine 7.5 mg #90 is not medically necessary. The injured worker complained of tingling and numbness in the right upper extremity. He complained of severe pain in his neck. He described his left leg pain as aching, throbbing, shooting and stabbing. The California MTUS Guidelines recommend nonsedating muscle relaxants with caution as a second-line option for the short-term treatment of acute exacerbations in injured workers with chronic low back pain. The guidelines note that the medication is not recommended to be used for longer than 2 to 3 weeks. Muscle relaxants may be effective in reducing pain and muscle tension and in increasing mobility. However, in most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. There was a lack of significant objective findings indicating that the injured worker is treated for muscle spasms. The injured worker had been utilizing the medication for an extended period of time, since at lest 02/2014, which exceeds the guideline recommendation for short-term use for 2 to 3 weeks. The request submitted failed to provide the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request for cyclobenzaprine 7.5 mg #90 is not medically necessary.

Oxycodone 20mg #60 (6 month supply): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): page(s) 78.

Decision rationale: The request for Oxycodone #60 for a 6 month supply is not medically necessary The injured worker complained of tingling and numbness in the right upper extremity. He complained of severe pain in his neck. He described his left leg pain as aching, throbbing, shooting and stabbing. The California MTUS Guidelines recommend the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is a lack of documentation indicating that the medication had been providing objective functional benefit and improvement. The injured worker had been utilizing the medication since at least 02/2014. Additionally, the use of a recent urine drug screen was not provided for clinical review. Also, the frequency of the medication was not provided for clinical review. Therefore, the request for Oxycodone 20 mg #60 for a 6 month supply is not medically necessary.