

Case Number:	CM14-0072570		
Date Assigned:	07/16/2014	Date of Injury:	11/06/2011
Decision Date:	09/17/2014	UR Denial Date:	04/23/2014
Priority:	Standard	Application Received:	05/19/2014

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, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

This is a 54-year-old male with a date of injury of 11/6/11. The mechanism of injury was not noted. On 2/13/14 and 3/13/14 he is noted to be on Remeron, Lyrica, Flexeril, OxyContin, and Norco. On 4/10/14, it was noted that he is on Halcion and Valium, prescribed by another MD. On dates 4/10/14, 5/9/14, 6/5/14, and 7/3/14, his medication regimen remained the same and there was noted appropriate Cures Report and Urine Drug Screens (UDS). On 4/10/14 he complained of abdominal pain and groin pain and needs medication refills. He stated he gets 50% relief from the opioids, and with his meds he can walk about 1 hour but not continuously. He can stand and sit for 1-2 hours with meds and 30 minutes without meds. His pain is 5/10 with meds and 9-10/10 without meds. On exam there is a well-healed scar present in the left lower quadrant of the abdomen. Palpation of the lateral aspect of the scar is painful. The diagnostic impression is low back pain. Treatment to date: medication management. A UR decision dated 4/23/14 denied Hydrocodone/Acetaminophen 10/325mg and Flexeril 10mg. The Hydrocodone/Acetaminophen (Norco) was denied because guideline mandated documentation for continued use of Norco had not been provided, despite previous warnings regarding the necessary documentation needed for continued Norco use. The provider has not fully complied with guideline recommendations and therefore, it is not certified. The Flexeril was denied because in this case, the patient has no complaints of exacerbation of low back pain and muscle spasm. Review of claim reveals that the patient has been certified with Flexeril 10mg #20, and guidelines recommend use of this medication for less than 2 weeks. This medication is apparently being utilized for long-term treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10-325mg #120: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 78-71.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. It was noted on reports from 4/10/14, 5/9/14, 6/5/14, and 7/3/14 that there were appropriate CURES Reports and UDS(s). The patient demonstrated functional improvement with his pain regimen, stating he receives 50% improvement in functions of daily living with the medications. The provider stated that the patient has gained good function with his current pain regimen and is aware of another MD prescribing his benzodiazepines. The prescribing MD has provided the appropriate documentation for continued opioid use by the documented improved functional status, and demonstrated appropriate medication use by the patient. The patient has had no adverse side effects from the medication regimen. Therefore, the request for Hydrocodone/Acetaminophen 10/325mg #120 was medically necessary.

Flexeril 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers Compensation Pain Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 41-42.

Decision rationale: According to page 41 of the MTUS Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended. However, there was no documentation of an acute exacerbation of the patient's chronic pain. In addition, this is noted to be a refill for Flexeril. The Guidelines do not support the long-term use of muscle relaxants due to diminishing efficacy over time and the risk of dependence. Therefore, the request for Flexeril 10mg #30 was not medically necessary.