

Case Number:	CM14-0075824		
Date Assigned:	07/16/2014	Date of Injury:	10/28/1997
Decision Date:	08/14/2014	UR Denial Date:	05/15/2014
Priority:	Standard	Application Received:	05/23/2014

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 Emergency 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:

This patient reported injury on 10/28/1997. The patient has diagnoses of right foot Lisfranc fracture, post surgical repair; post removal of hardware and repair of anterior tibial tendon and a fusion procedure; and complex regional pain syndrome. The injured worker had a spinal cord stimulator placed with mild benefits, but it was removed due to complications. The only records reviewed were a utilization review (UR) assessment report and an appeal letter dated 5/23/14. Older records were not provided for my review. The patient complains of lower extremity burning pain on both feet and legs, as well as low back pains. The objective exam reveals the patient is using a walker and a wheelchair, with antalgic gait noted. Also noted are spasms in the lumbar spine, positive sciatic notch tenderness to the left side, none in the right side. The patient demonstrated limited range of motion and straight leg raise on left side to 50. The UR report notes a history of surgeries, as well as the use of NSAIDs (non-steroidal anti-inflammatory drugs), muscle relaxants, opioids, and benzodiazepines. It also notes prior acupuncture and physical therapy and failure of a prior functional restoration program. As per the treating physician's response to the UR denial letter, the patient's use of Flexeril helps with pain and prevents the patient from being completely homebound. The treating physician notes that the patient only uses it intermittently, during muscle spasm flare ups. There is no mention of the modification of requested Ativan to 12 tablets in that letter. No advance imaging or reports were provided. Independent Medical Review was requested for a prescription of Ativan 2mg #15 and Flexeril 10mg #90. The UR on 5/15/14 certified Norco, modified the Ativan prescription to 12 tablets, and non-certified Flexeril.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription for Ativan 2mg #15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 23.

Decision rationale: Ativan is a benzodiazepine, a sedative/hypnotic. As per MTUS Chronic Pain Guidelines, it is only recommended for short-term use due to high tolerance and side effects. The patient is taking the medication chronically. A prior UR recommended tapering the patient off Ativan. Ativan is not medically necessary.

1 prescription for Flexeril 10mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for Pain. Decision based on Non-MTUS Citation Return to Work Guidelines (2010 Official Disability Guidelines, 15th edition) Integrated Treatment Guidelines (ODG Treatment in Workers' Comp, 8th edition) Pain, Chronic.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 64.

Decision rationale: Cyclobenzaprine, or Flexeril, is a muscle relaxant. As per MTUS Chronic Pain guidelines, it is recommended for muscle spasms. It is recommended for short-term use and has mixed evidence for chronic use, with no specific recommendation for chronic use. The patient has documented muscle spasms and chronic pain that is not likely to improve in the short or even long term. The patient has reported improvement in muscle spasms and pain with Flexeril that allows the patient to leave the house. The treating physician notes close monitoring for abuse, and the patient only uses the medication intermittently. The continued intermittent use of Flexeril is medically necessary.