

<b>Case Number:</b>	CM15-0004706		
<b>Date Assigned:</b>	01/16/2015	<b>Date of Injury:</b>	03/08/2000
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	12/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New York  
 Certification(s)/Specialty: Pediatrics, Internal Medicine

### 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 female, who sustained an industrial injury on 3/8/2000 and 2/22/2001. She has reported low back, neck and bilateral knee pain. The diagnoses have included chronic neck pain, chronic low back pain, right sided thoracic pain, bilateral shoulder pain, headaches, insomnia and depression and anxiety. Treatment to date has included chiropractic treatment, right knee surgery, medications and acupuncture. (MRI) magnetic resonance imaging was performed of lumbar region was performed in 2006 and again in 3/13 revealed mild lumbar spondylosis, multilevel annular bulges slightly larger at L3-L4 and L4-L5, no canal or foraminal stenosis. (MRI) magnetic resonance imaging of thoracic spine performed in 3/13 revealed compression fracture in mid to lower thoracic level. Currently, the IW complains of persistent symptoms in neck, thoracic and low back area. The physical exam performed on 5/14/14 revealed decreased range of motion of C-spine, thoracic and lumbar spine. She has good strength and sensory findings were not consistent. On 12/28/14 Utilization Review non-certified prescriptions for Nexium 40 mg #30 with 3 refills, noting there is no documentation of gastrointestinal disorder and Flexeril 10 mg #30, noting it is only recommended for a short period of time and submitted modified certifications for OxyContin 40 mg, # 60 to # 45, noting opioids are not recommended for chronic pain, modified certification for weaning; and Imitrex nasal spray with 3 refills to 0 refills, noting the CA MTUS does not provide recommendations for use of Imitrex in management of headaches. MTUS, ACOEM Guidelines, was cited. On 1/7/15, the injured worker submitted an application for IMR for review of OxyContin 40 mg # 60, Imitrex nasal spray with 3 refills, Nexium 40 mg # 30 with 3 refills and Flexeril 10 mg # 30.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycontin 40mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opiods, criteria for use4) On-Going Management Page(s): 78.

**Decision rationale:** The IW has been on long term opioids which is not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary and reasonable at this time.

**Imitrex nasal spray with 3 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Head (Trauma, Headaches, etc).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UpToDate.

**Decision rationale:** The California Medical Treatment Utilization Schedule and the Official Disability Guidelines do not provide recommendations on the use of Imitrex for the treatment of headaches. UpToDate was consulted for treatment indications, dosing and interactions. Imitrex is indicated for treatment of migraines and cluster headache. The documentation indicates that the IW had a diagnosis of headache not migraine or cluster headache. This request is not medically necessary and appropriate at this time.

**Nexium 40mg #30 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

**Decision rationale:** The MTUS guidelines indicate that a gastrointestinal (GI) protectant should be initiated in patients with an intermediate or high risk of GI bleeding with use of an NSAID. There is no indication in the documentation that this IW was at elevated risk for a GI bleed. This request is not medically necessary and appropriate at this time.

**Flexeril 10mg #30:** Upheld

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

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

**Decision rationale:** Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. The greatest effect appears to be in the first 4 days of treatment. The documentation does not reference any muscle spasm that the Flexeril would be used for and at this time frame it is not indicated. This request is not medically necessary and appropriate at this time.