

Case Number:	CM15-0187640		
Date Assigned:	09/29/2015	Date of Injury:	11/04/1999
Decision Date:	11/09/2015	UR Denial Date:	09/21/2015
Priority:	Standard	Application Received:	09/23/2015

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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 41 year old female, who sustained an industrial injury on 11-04-1999. She has reported injury to the bilateral wrists. The diagnoses have included reflex sympathetic dystrophy; sprain-strain of neck; and lumbar degenerative disc disease. Treatment to date has included medications, diagnostics, and home exercise regimen. Medications have included Oxycontin, Oxycodone, Topamax, Flector Patch, Cylobenzaprine, Trazodone, and compounded topical creams. A progress report from the treating physician, dated 07-22-2015, documented a follow-up visit with the injured worker. The injured worker reported pain in the bilateral wrists; the pain is described as constant, sharp, dull, aching, throbbing, pins and needles, stabbing, numbness, weakness, and spasm; the current pain rating (good day) is noted as 8 out of 10 in intensity; the current pain rating (bad day) is noted as 10 out of 10 in intensity; aggravating factors include heat, cold, sitting, and standing; alleviating factors include medication and massage; she has bilateral neck and lumbar spasms; and she is obtaining functional pain control with the current medication regimen. Objective findings included she is in no acute distress; tenderness to palpation at C7-C8; mild bilateral paracervical tenderness, right greater than left; decreased cervical spine ranges of motion; tenderness to palpation at L4-L5; bilateral paralumbar tenderness and spasm; lumbar ranges of motion are decreased; bilateral cervical and bilateral lumbar spine spasms are noted; there is swelling, hyperhidrosis, and coolness in the distal right upper extremity greater than left upper extremity; right handgrip is noted as 4+ out of 5; decreased sensation to pain at the entire right upper extremity; allodynia right hand; and decreased light touch sensation at the right upper extremity. The treatment plan has included the

request for Oxycodone HCl 30mg #60; Oxycontin 80mg #120; and Cyclobenzaprine HCl 10mg #240. The original utilization review, dated 09-21-2015, modified the request for Oxycodone HCl 30mg #60, to Oxycodone HCl 30mg #32; modified the request for Oxycontin 80mg #120, to Oxycontin 80mg #68; and non-certified the request for Cyclobenzaprine HCl 10mg #240.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone HCL 30mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page 79, 80 and 88 of 127. This claimant was injured in 1999. There were bilateral wrist injuries, reflex sympathetic dystrophy, sprain of the neck, and lumbar degenerative disc disease. The opiates were modified in the previous utilization review. The current California web-based MTUS collection was reviewed in addressing this request. They note in the Chronic Pain section: When to Discontinue Opioids: Weaning should occur under direct ongoing medical supervision as a slow taper except for the below mentioned possible indications for immediate discontinuation. They should be discontinued: (a) If there is no overall improvement in function, unless there are extenuating circumstances. When to Continue Opioids: (a) If the patient has returned to work; (b) If the patient has improved functioning and pain. In the clinical records provided, it is not clearly evident these key criteria have been met in this case. The request for the opiate usage is not medically necessary per MTUS guideline review.

Oxycontin 80mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Page 79, 80 and 88 of 127. As shared, this claimant was injured in 1999. There were bilateral wrist injuries, reflex sympathetic dystrophy, sprain of the neck, and lumbar degenerative disc disease. The opiates were modified in the previous utilization review. In regards to the long term use of opiates, the MTUS also poses several analytical necessity questions such as: has the diagnosis changed, what other medications is the patient taking, are they effective, producing side effects, what treatments have been attempted since the use of opioids, and what is the documentation of pain and functional improvement and compare to baseline. These are important issues, and they have not been addressed in this case. As shared earlier, there

especially is no documentation of functional improvement with the regimen. The request for the opiate usage is not medically necessary per MTUS guideline review.

Cyclobenzaprine HCL 10mg #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: Chronic Pain Medical Treatment Guidelines MTUS 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 41-42 of 127. As noted previously, this claimant was injured in 1999. There were bilateral wrist injuries, reflex sympathetic dystrophy, sprain of the neck, and lumbar degenerative disc disease. The opiates were modified in the previous utilization review. The MTUS recommends Flexeril (cyclobenzaprine) for 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. The addition of cyclobenzaprine to other agents is not recommended. In this case, there has been no objective functional improvement noted in the long-term use of Flexeril in this claimant. Long-term use is not supported. It is being used with other agents, which also is not clinically supported in the MTUS. The request is not medically necessary.