

<b>Case Number:</b>	CM15-0050644		
<b>Date Assigned:</b>	03/24/2015	<b>Date of Injury:</b>	08/14/2001
<b>Decision Date:</b>	05/04/2015	<b>UR Denial Date:</b>	03/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/17/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 53 year old male patient who sustained an industrial injury on 08/14/2001. Prior diagnostic testing includes radiography study, magnetic resonance imaging, trial of spinal cord stimulator, placed on 05/01/2014, prior spinal surgeries (3), hot/cold application, and oral analgesia. A follow up visit dated 02/23/2015 showed the patient with chief complaint of low back pains unchanged, and lower extremity pains are noted improved with spinal cord stimulator. Of note, the patient's symptom began on 08/14/2001 with the onset of low back and lower extremity pains. In addition, he complains of experiencing lower extremity muscle cramps. His urine drug screens have been consistent with prescribed medications. Prior medications include Flexeril and Hydrocodone. Current medication regimen consists of Flexeril, Percocet and Lyrica. The impression noted failed back surgical syndrome, status post fusion L2-S1; status post multiple lumbar radiculopathies with right foot drop; lumbar spondylosis, chronic pain syndrome and long-term Opiate use. He is to follow up in 4 weeks. The plan of care involved refilling Percocet 10/325mg #68, continue Flexeril, refill Lyrica, continue with home exercise program, and continue working with rep of spinal cord stimulator.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325 mg, 68 count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78 - 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

**Decision rationale:** Percocet 10/325 mg, 68 count is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS Chronic Pain Medical Treatment Guidelines a satisfactory response to opioid treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The MTUS also recommends opioid prescribing in accordance with monitoring of the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The documentation reveals that the patient has been on long term opioids without significant functional improvement. There is also evidence of an inconsistent urine drug screen on 12/1/14. For all of these reasons the request for continued Percocet is not medically necessary.

**Flexeril 10 mg, ninety count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63 - 66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42 and 64.

**Decision rationale:** Flexeril 10mg ninety count is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that Flexeril is not recommended to be used for longer than 2-3 weeks. The documentation indicates that the patient has already been on Flexeril. There is no evidence of functional improvement from prior use. There are no extenuating circumstances documented that would necessitate continuing this medication beyond the 2-3 week time frame. The request for Flexeril is not medically necessary.