

Case Number:	CM15-0126579		
Date Assigned:	07/13/2015	Date of Injury:	03/26/2007
Decision Date:	08/06/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	06/30/2015

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: Arizona, California

Certification(s)/Specialty: Family Practice

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 54 year old male who sustained an industrial injury on 3/26/07 in a fall from five feet twisting his back and injuring his left foot and neck. He currently complains of back pain radiating down both legs. Without medication his pain level was 8/10. His sleep quality is poor and his activity level has decreased. On physical exam of the lumbar spine there was restricted range of motion, with tenderness and spasms on palpation of the paravertebral muscles and hypertonicity and positive sitting straight leg raise bilaterally. Medications were Senokot, Lodine, gabapentin, Pristiq, Lunesta, MS Contin, and Norco. Diagnoses include disc disorder lumbar spine; post lumbar laminectomy syndrome; depression with anxiety. Treatments to date include medications; psychological evaluation. In the progress note dated 2/11/15 the treating provider's plan of care includes requests for new car lift for motorized scooter; MS Contin as it controls pain and allows him to perform activities of daily living; trial of Flexeril 10mg twice per day for spasms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 10mg #60 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril Page(s): 63.

Decision rationale: According to the MTUS guidelines, Cyclobenzaprine (Flexeril) is more effective than placebo for back pain. It is recommended for short course therapy and has the greatest benefit in the first 4 days suggesting that shorter courses may be better. Those with fibromyalgia were 3 times more likely to report overall improvement, particularly sleep. Treatment should be brief. There is also a post-op use. The addition of Cyclobenzaprine to other agents is not recommended. In this case the request for 2 months of Flexeril supply was not justified and was provided in combination with multiple opioids. Based on the above, the request for Cyclobenzaprine is not medically necessary.

Morphine Sulfate (MS) Contin #60 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 82-92.

Decision rationale: According to the guidelines, Morphine is not 1st line for lumbar root pain. It is not indicated for mechanical or compressive etiologies. In this case, the claimant has been on Morphine along with Norco for over a year. Pain reduction was better previously than currently- indicating tolerance. In addition, there is no indication of weaning. Long-term use has not been studied. Failure of Tricyclics is not noted. Additional month refill cannot be justified in advance. As a result, the request for the above is not medically necessary.

1 repair of car lift for motorized scooter: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines motorized wheelchair Page(s): 98.

Decision rationale: According to the guidelines, power mobility devices are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. In this case, the claimant had an antalgic gait and tremors in the right hand. In addition, the back pain was worsening and persistent. However, the physician had encouraged the claimant to walk and exercise indicating he is not immobile. The request for repair of the scooter is not medically necessary.