

Case Number:	CM15-0173960		
Date Assigned:	09/15/2015	Date of Injury:	11/07/2013
Decision Date:	10/22/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/03/2015

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: California, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 48 year old male, who sustained an industrial injury on 11-7-13. Medical record indicated the injured worker is undergoing treatment for cervical sprain-strain with spondylosis and thoracolumbar sprain-strain with spondylosis with prolapsed disc versus osteophyte with failed epidural injection. Treatment to date has included oral medications including Tramadol, Flexeril, epidural injections and activity modifications. On 7-14-15 the injured worker complained of persistent low back pain with radiation to the left lower extremity with numbness and tingling in left lower extremity rated 8 out of 10 and continued neck pain rated 7-8 out of 10 with radiation to the left shoulder with numbness and tingling in the left shoulder and on 8-25-15, the injured worker complains of continued back pain and neck pain and notes he has decided not to have low back surgery. Work status is noted to be return to modified duties. Physical exam performed on 7-14-15 and 8-25-15 revealed restricted cervical and lumbar range of motion. Request for authorization was submitted on 8-26-15 for Ultram 50mg #60 with 1 refill and Flexeril 10mg #60 with 1 refill. On 9-2-15, utilization review modified a request for Ultram 50mg #60 with 1 refill noting there is no documentation of monitoring of analgesia, activities of daily living, adverse side effects and aberrant drug taking behaviors with opioid use. Weaning is suggested; therefore one month supply was certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram 50mg #60 with 1 refill: 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, criteria for use.

Decision rationale: The patient presents with pain affecting the low back with radiation to the left lower extremity, and neck with radiation to the left shoulder. The current request is for Ultram 50mg #60 with 1 refill. The requesting treating physician report dated 8/24/15 (79B) provides no rationale for the current request. The report does note that the prescription for Ultram is for "moderate pain". MTUS pages 88 and 89 states "document pain and functional improvement and compare to baseline, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS also requires documentation of the four A's (analgesia, ADL's, Adverse effects and Adverse behavior). The medical reports provided, show the patient has been taking Ultram since at least 3/5/15 (26B). The report dated 7/13/15 (61B) notes that the patient's pain level is 7-8/10. No adverse effects or adverse behavior were discussed by the patient. The patient's last urine drug screen was not available for review and there is no evidence provided that shows the physician has a signed pain agreement or cures report on file. In this case, all four of the required A's are not addressed, the patient's pain level has not been assessed at each visit, and functional improvement has not been documented. The MTUS guidelines require much more thorough documentation to recommend the continued usage of Ultram. The current request is not medically necessary.

Flexeril 10mg #60 with 1 refill: 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): Muscle relaxants (for pain).

Decision rationale: The patient presents with pain affecting the low back with radiation to the left lower extremity, and neck with radiation to the left shoulder. The current request is for Flexeril 10mg #60 with 1 refill. The treating physician report dated 6/02/15 (51B) states, "Flexeril 10 mg b.i.d. p.r.n. for spasm #60 with 1 refill". MTUS guidelines for muscle relaxants state the following: "Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use". MTUS guidelines for muscle relaxants for pain page 63 states the following: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP". MTUS does not recommend more than 2-3 weeks for use of this medication. The medical

reports provided indicate that the patient has been taking this medication since at least 6/2/15 (51B). In this case, the use of the medication is outside the 2-3 weeks recommended by MTUS. Furthermore, the current request for 1 refill is excessive and exceeds the recommended dosage for a 2-3 week period. The current request does not satisfy the MTUS guidelines as outlined on page 63. The current request is not medically necessary.