

Case Number:	CM14-0143677		
Date Assigned:	09/12/2014	Date of Injury:	04/07/1999
Decision Date:	10/07/2014	UR Denial Date:	09/04/2014
Priority:	Standard	Application Received:	09/04/2014

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. The expert reviewer is Board Certified in Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 56-year-old man who sustained a work-related injury on April 7, 1999. Subsequently, he developed chronic neck and back pain. The patient has a history of colon cancer with metastasis to liver, vertebral body compression at T11 with significant kyphosis. The patient had a lumbar laminectomy in 1993, lumbar fusion in 2002, CA of the colon diagnosed in 2005, colostomy and colectomy for CA in 2005, and Medtronic pump implant in 2005. The follow-up report dated June 3, 2014 reported a fracture of vertebral body. The patient reported that his pain was stabilized with a combination of Morphine, Clonidine, and Bupivacaine. According to the progress report dated July 29, 2014, the patient has recently started on oral chemotherapy for his cancer. The patient has been complaining of weakness of upper extremities, especially right upper extremity for which he has been trying to exercise as much as possible. The pain level is rated at a 6/10. His physical examination demonstrated spine tenderness in the area to percussion over the areas of T10 and T11. The patient was diagnosed with non-healing T10-11 fracture, lumbar facet arthropathy, failed back surgery, lumbar arachnoiditis, and history of CA of the colon with metastasis to liver and diaphragmatic hernia. The provider requested authorization for Flexeril and pain pump refill every 2 months (lifetime).

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril tablets 10mg twice a day QTY: 120: Upheld

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

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

Decision rationale: According to MTUS guidelines, Flexeril, a non sedating muscle relaxants, is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic spasm and pain. Efficacy appears to diminish over time and prolonged use may cause dependence. There is no recent documentation of pain and spasticity of the patient. There is no documented functional improvement from its previous use. Therefore the request for FLEXERIL 100 mg, # 120 is not medically necessary.

Pain pump refill every 2 moths (lifetime): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Intrathecal drug delivery system Page(s): 54-55.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines IMPLANTABLE DRUG-DELIVERY SYSTEMS Page(s): 52.

Decision rationale: According to MTUS guidelines, <Implantable drug-delivery systems (IDDSs) is recommended only as an end-stage treatment alternative for selected patients for specific conditions indicated below (Cancer conditions), after failure of at least 6 months of less invasive methods, and following a successful temporary trial>. There is no documentation of type of medications prescribed through the pump nor the concentration, dose and flow rate. Furthermore, a pain pump approval refill every 2 months (lifetime) cannot be justified without periodic evaluation of its efficacy. Therefore, the request for PAIN PUMP REFILL every 2 months (lifetime) is not medically necessary.