

Case Number:	CM13-0012968		
Date Assigned:	09/18/2013	Date of Injury:	12/29/2002
Decision Date:	02/21/2014	UR Denial Date:	07/25/2013
Priority:	Standard	Application Received:	08/13/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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 physician 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:

This is a female patient with the date of injury of December 29, 2002. A utilization review determination dated July 25, 2013 recommends non-certification of Zanaflex 4mg #30, Lyrica 150mg #60, Fentanyl 25mcg/hr. patch #10, and Percocet 10-325mg #60. The previous reviewing physician recommended non-certification of Zanaflex 4mg #30 due to lack of documentation of support for long-term use; non-certification of Lyrica 150mg #60 due to lack of documentation of an indication for Lyrica and the patient's specific functional response to this medication; non-certification of Fentanyl 25mcg/hr. patch #10 due to not being recommended for musculoskeletal pain; and non-certification of Percocet 10-325mg #60 due to lack of documentation of how much pain relief, improvement in function, and quality of life the patient is receiving from her narcotic therapy. A Progress Report dated August 16, 2013 identifies Chief Complaint of lower back pain, radiating pain to both lower extremities. Physical exam identifies severe tenderness over cervical area bilaterally and limited range of motions in all directions. Tenderness over paracervical, trapezius, and rhomboid area. SLR positive on left side at 35 degrees and on right side at 45 degrees. Diffuse tenderness over lower lumbar area and sacroiliac joint. Range of motion limited. Gait is antalgic, very slow, limps on left side. Bilateral paralumbar spasm. Weakness diffusely in both lower extremities. Left hand grip weakness. Sensation to pin is decreased right C8. Light touch is decreased in both lower extremities. Assessment and Plan includes SCS implant lumbar, failed back surgery syndrome, lumbar radiculopathy, cervical radiculopathy left, occipital neuralgia, depression major, myofascial pain syndrome, shoulder impingement syndrome right. Medication Summary identifies continues the patient's current medication. Continue with conservative treatment to include home exercise program, moist heat, and stretches. Medication Management ide

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4 mg, #30: Upheld

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

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

Decision rationale: Regarding the request for Zanaflex 4 mg, #30, Chronic Pain Medical Treatment Guidelines recommend muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Within the medical information made available for review, there is no documentation of an acute exacerbation. In addition, there is no mention that the requested Zanaflex will be used as short-term treatment. In the absence of such documentation, the currently requested Zanaflex 4 mg, #30 is not medically necessary.

Lyrica 150 mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-21.

Decision rationale: Regarding request for Lyrica, Chronic Pain Medical Treatment Guidelines state that ant epilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS), and no documentation of specific objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. In the absence of such documentation, the currently requested Lyrica is not medically necessary.

Fentanyl 25 mcg/hr. patch, #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG);

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79.

Decision rationale: Regarding the request for Fentanyl 25 mcg/hr. patch, #10, Chronic Pain Medical Treatment Guidelines state Fentanyl is not recommended as a first-line therapy. The Guidelines also state it is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. Within the medical information made available for review, there is documentation of chronic pain. However, there is no mention of failure of first-line therapy. There is no mention that the patient's chronic pain requires continuous opioid analgesia and the pain cannot be managed by other means. In the absence of such information, the currently requested Fentanyl 25 mcg/hr. patch, #10 is not medically necessary.

Percocet 10-325 mg, #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79.

Decision rationale: Regarding the request for Percocet 10-325 mg, #60, California Pain Medical Treatment Guidelines state that Percocet is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, it is stated that the Percocet provides good pain control and increased physical activity, improvement in activities of daily living, mood as well as sleep. It is noted that the patient reports no side effects from current medication and no aberrant behavior. As such, the currently requested Percocet 10-325 mg, #60 is medically necessary.