

Case Number:	CM13-0016423		
Date Assigned:	03/12/2014	Date of Injury:	05/09/1997
Decision Date:	08/15/2014	UR Denial Date:	08/21/2013
Priority:	Standard	Application Received:	08/26/2013

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 Physical Medicine & Rehabilitation 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 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 injured worker is a 55-year-old female who reported an injury on May 09, 1997. The mechanism of injury was not provided for review. The injured worker reported sustained an injury to her low back. The injured worker's treatment history included multiple conservative measures, surgical intervention, and spinal cord implantation. The most recent clinical evaluation submitted for review is dated May 25, 2013. Physical examination findings included paresthesia and neuropathy in her fingers with decreased grip strength and no specific evidence of atrophy. A request was made for a refill of medications; however, no justification for the request was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitiza (24mcg, 3-month supply): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary; and on the Non-MTUS Mosby's Drug Consult; as well as the Non-MTUS Veterans Health Administrations, Department of Defense Clinical Practice Guideline.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: The requested Amitiza is not medically necessary or appropriate. The clinical documentation submitted for review did not provide a recent assessment of the injured worker's medication usage. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit and evidence of pain relief. It is also recommended that the injured worker be monitored for aberrant behavior. The clinical documentation submitted for review does not provide any recent evidence of functional benefit or pain relief resulting from medication usage. Additionally, there is no documentation that the injured worker is monitored for aberrant behavior. The request is for a 3-month supply. This does not allow for ongoing assessment and re-evaluation to support continued use. Furthermore, the request as it is submitted does not specifically identify a quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

Keflex (3-month supply): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Infectious Disease chapter, Cephalexin (Keflex®).

Decision rationale: The requested Keflex is not medically necessary or appropriate. The clinical documentation submitted for review did not include a recent assessment of the injured worker. The California Medical Treatment Utilization Schedule does not address Keflex. The Official Disability Guidelines recommend the use of Keflex as a first line medication for cellulitis and other types of infections. There was no documentation to support that the injured worker has any type of infection that would require an antibiotic. Additionally, there is no documentation of a need for 3 months of an antibiotic. Furthermore, the request as it is submitted does not clearly identify a dosage, quantity, or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

Cymbalta (30mg, 3-month supply): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Depressants and Medications for Chronic pain Page(s): 13, 60.

Decision rationale: The requested Cymbalta is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends antidepressants as a first line medication in the management of chronic pain. However, the California Medical Treatment Utilization Schedule recommends the continued use of medications in the management of

chronic pain be supported by documented functional benefit and evidence of pain relief. The clinical documentation did not include a recent assessment of the injured worker to support the need for this medication. Additionally, a 3-month supply does not allow for timely re-evaluation and assessment of efficacy. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

Diflucan (3-month supply): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain and NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 60 and 16.

Decision rationale: The requested Diflucan is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does support the use of nonsteroidal anti-inflammatory drugs in the management of chronic pain. However, the California Medical Treatment Utilization Schedule recommends continued use be supported by documented functional benefit and evidence of pain relief. The clinical documentation submitted for review did not include a recent assessment of the injured worker to support the need for this medication. Additionally, a 3-month supply does not allow for timely re-evaluation and efficacy to support continued use. Furthermore, the request as it is submitted did not clearly identify a dosage, frequency, or quantity. Therefore, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

Ambien CR (10mg, 3-month supply): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary; and on the Non-MTUS Mosby's Drug Consult.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia Treatments.

Decision rationale: The requested Ambien CR is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines do not support the long-term use of Ambien. There is no recent documentation to support the need for this medication. Additionally, a 3-month supply exceeds Guideline recommendations of a short duration of treatment. Furthermore, the request as it is submitted does not clearly identify a quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

Provigil (3-month supply): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Provigil.

Decision rationale: The requested Provigil is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this request. The Official Disability Guidelines recommend the use of Provigil for symptoms related to narcolepsy. It is not supported for the use of side effects related to opioid analgesics. The clinical documentation did not include a recent assessment of the injured worker to support the need for this medication. Additionally, the requested 3 months does not allow for timely re-assessment or evaluation. Furthermore, the request as it is submitted does not clearly identify a dosage, frequency, or duration of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

Percocet (10/325mg, 3-month supply): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acetaminophen (APAP); Opioids, Criteria for use; Opioids for Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, page Page(s): 78.

Decision rationale: The requested Percocet is not medically necessary or appropriate. The clinical documentation submitted for review did not provide a recent assessment of the injured worker's medication usage. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit and evidence of pain relief. It is also recommended that the injured worker be monitored for aberrant behavior. The clinical documentation submitted for review does not provide any recent evidence of functional benefit or pain relief resulting from medication usage. Additionally, there is no documentation that the injured worker is monitored for aberrant behavior. The request is for a 3-month supply. This does not allow for ongoing assessment and re-evaluation to support continued use. Furthermore, the request as it is submitted does not specifically identify a quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

Tylenol with Codeine (300/60mg, 3-month supply): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acetaminophen (APAP); Opioids, Criteria for use; Opioids for Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested Tylenol with Codeine is not medically necessary or appropriate. The clinical documentation submitted for review did not provide a recent assessment of the injured worker's medication usage. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by documentation of functional benefit and evidence of pain relief. It is also recommended that the injured worker be monitored for aberrant behavior. The clinical documentation submitted for review does not provide any recent evidence of functional benefit or pain relief resulting from medication usage. Additionally, there is no documentation that the injured worker is monitored for aberrant behavior. The request is for a 3-month supply. This does not allow for ongoing assessment and re-evaluation to support continued use. Furthermore, the request as it is submitted does not specifically identify a quantity or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

Celebrex (200mg, 3-month supply): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) and Medications for Chronic pain Page(s): 16, 60.

Decision rationale: The requested Celebrex is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does support the use of nonsteroidal anti-inflammatory drugs in the management of chronic pain. However, the California Medical Treatment Utilization Schedule recommends continued use be supported by documented functional benefit and evidence of pain relief. The clinical documentation submitted for review did not include a recent assessment of the injured worker to support the need for this medication. Additionally, a 3-month supply does not allow for timely re-evaluation and efficacy to support continued use. Furthermore, the request as it is submitted did not clearly identify a dosage, frequency, or quantity. Therefore, the appropriateness of the request cannot be determined. As such, the request is not medically necessary or appropriate.

Modafinil (3-month supply): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Provigil.

Decision rationale: The requested Modafinil is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address this request. The Official

Disability Guidelines recommend the use of Provigil for symptoms related to narcolepsy. It is not supported for the use of side effects related to opioid analgesics. The clinical documentation did not include a recent assessment of the injured worker to support the need for this medication. Additionally, the requested 3 months does not allow for timely re-assessment or evaluation. Furthermore, the request as it is submitted does not clearly identify a dosage, frequency, or duration of treatment. Therefore, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

Topiramate (3-month supply): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIEPILEPSY DRUGS (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Anti-Epileptics Page(s): 60 and 16.

Decision rationale: The requested Topiramate is not medically necessary or appropriate. The clinical documentation submitted for review does not provide a recent evaluation to support the need for this medication. The California Medical Treatment Utilization Schedule does recommend the use of anticonvulsants in the management of chronic pain. However, the use of medications in the management of chronic pain should be supported by documented functional benefit and evidence of pain relief. The clinical documentation submitted for review does not provide any evidence of pain relief or functional benefit to support continued use. A 3-month supply does not allow for adequate re-assessment to support efficacy and continued use. Furthermore, the request as it is submitted does not clearly identify a quantity, dosage, or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

Omeprazole (20mg, 3-month supply): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The requested Omeprazole is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of gastrointestinal protectants for patients who are at risk for development of gastrointestinal events related to medication usage. The clinical documentation did not include a recent assessment to support the need for this medication. There is no documentation of significant risk factors for gastrointestinal disturbances that would require medication management. The request for a 3-month supply would not allow for a timely re-assessment and evaluation to support continued use. Furthermore, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.

Voltaren Gel (3-month supply): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The requested Voltaren Gel is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend the long-term use of topical nonsteroidal anti-inflammatory drugs. The requested 3-month supply exceeds the 2-4 week recommendation. Additionally, the clinical documentation submitted for review does not include a recent assessment of the injured worker to support the need for medication management. Furthermore, the request as it is submitted does not clearly define a frequency of treatment or applicable body part. Therefore, the appropriateness of the request itself cannot be determined. As such, the request is not medically necessary or appropriate.