

Case Number:	CM13-0021690		
Date Assigned:	12/13/2013	Date of Injury:	10/25/2010
Decision Date:	02/10/2014	UR Denial Date:	08/23/2013
Priority:	Standard	Application Received:	09/06/2013

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, and is licensed to practice in New York and Texas. 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:

The patient is a 56-year-old who reported an injury on 10/25/2010. The patient is diagnosed as status post ACDF (anterior cervical discectomy and fusion) in 2012, cervical disc degenerative disease, and PTSD (post-traumatic stress disorder). The most recent primary treating physician progress report was submitted on 10/31/2012 by [REDACTED]. The patient reported persistent pain with restricted range of motion. Physical examination revealed 5/5 motor strength, decreased sensation to light touch over the left upper extremity, and trace reflexes for brachioradialis and triceps bilaterally. X-rays obtained in the office on that date indicated osteo metallic fusion which appears to be incorporating nicely. Treatment recommendations included continuation of current exercise program and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta, 30mg, 30 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16..

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines state antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in the use of other analgesic medication, sleep quality and duration, and a psychological assessment. Cymbalta is FDA approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. It is also used off label for neuropathic pain and radiculopathy. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite the ongoing use, the patient continues to report restricted range of motion and bilateral hand numbness. Satisfactory response to treatment has not been indicated by a decrease in pain level, a change in the use of other analgesic medication, an increase in function, or a change in psychological assessment. The request Cymbalta, 30mg, 30 count, for is not medically necessary or appropriate.

Imitrex 100mg, 27 count: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Triptans Section

Decision rationale: The Physician Reviewer's decision rationale: Official Disability Guidelines state triptans are recommended for migraine sufferers. At marketed doses, all oral triptans are effective and well-tolerated. Differences among them are, in general, relatively small, but clinically relevant for individual patients. As per the clinical notes submitted, there is no indication that this patient suffers from chronic headaches or migraine episodes. The medical necessity for the requested medication has not been established. The request Imitrex 100mg, 27 count, for is not medically necessary or appropriate.

Ondansetron HCL, 4ml, 90 count: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com

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

Decision rationale: The Physician Reviewer's decision rationale: The Official Disability Guidelines state ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. Ondansetron has been FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment, and is also approved for postoperative use. The patient does not appear to meet criteria for the use of this medication. The request for Ondansetron HCL, 4ml, 90 count, is not medically necessary or appropriate.

Clonazepam, 0.5mg, 120 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines state benzodiazepines are not recommended for long term use, because long term efficacy is unproven and there is a risk of dependence. Most guidelines limit the use to 4 weeks. A more appropriate treatment for anxiety disorder is an antidepressant. It is unclear whether the patient utilizes this medication for chronic pain, anxiety, or depression. Despite the ongoing use, the patient continues to report persistent pain with restricted range of motion. There are no palpable muscle spasms or muscle tension noted upon physical examination. As guidelines do not recommend chronic use of this medication, the current request cannot be determined as medically appropriate. The request for Clonazepam, 0.5mg, 120 count, is not medically necessary or appropriate.

Voltaren, 500 count: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines state NSAIDs (non-steroidal anti-inflammatory drugs) are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. It is recommended for osteoarthritis. There is no evidence to recommend 1 drug in this class over another based on efficacy. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. It was noted on 10/31/2012 that the patient utilizes Voltaren gel. It is unclear whether the patient utilizes the topical analgesic or the oral medication. Despite the ongoing use, the patient continues to report persistent pain with restricted range of motion. Satisfactory response to treatment has not been indicated. Therefore, the ongoing use cannot be determined as medically appropriate. The request for Voltaren, 500 count, is not medically necessary or appropriate.

Lidoderm 5%, 90 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. There is no evidence of a failure to respond to first line treatment with oral antidepressants and anticonvulsants. Therefore, the current request cannot be determined as medically appropriate. The request for Lidoderm 5%, 90 count, is not medically necessary or appropriate.

Flector 1.3%, 60 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. There is no evidence of a failure to respond to first line treatment with oral antidepressants and anticonvulsants. Therefore, the current request cannot be determined as medically appropriate. The request for Flector 1.3%, 60 count, is not medically necessary or appropriate.

Cymbalta 60mg, 60 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines state antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in the use of other analgesic medication, sleep quality and duration, and a psychological assessment. Cymbalta is FDA approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. It is also used off label for neuropathic pain and radiculopathy. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite the ongoing use, the patient continues to report restricted range of motion and bilateral hand numbness.

Satisfactory response to treatment has not been indicated by a decrease in pain level, a change in the use of other analgesic medication, an increase in function, or a change in psychological assessment. Therefore, ongoing use cannot be determined as medically appropriate. The request for Cymbalta 60mg, 60 count, is not medically necessary or appropriate.