

Case Number:	CM13-0043203		
Date Assigned:	12/27/2013	Date of Injury:	05/22/1997
Decision Date:	04/25/2014	UR Denial Date:	10/24/2013
Priority:	Standard	Application Received:	10/31/2013

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 and Rehabilitation, has a subspecialty in Interventional Spine 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 expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records: This patient is a 50 year-old male with date of injury 05/22/1997. Per the treater's report on 10/15/2013, the patient presents with neck pain radiation down both arms, back pain radiation down both legs, intensity of pain is 7/10 to 9/10 characterized by numbness, sharp, shooting, stabbing, tingling pain and pain is constant. The patient also has headaches, numbness and tingling of affected limb and weakness. The patient does not feel that current pain medications Final Determination Letter for IMR Case Number CM13-0043203 3 are providing adequate pain control and the medications are not effective and would like to increase dose of medications. The level of functionality, the patient has decreased. The patient has also tried intrathecal pump. TENS units that have not helped. Currently listed medications were diazepam, Dilaudid 8 mg 1 daily, fentanyl, and Seroquel. Oswestry Index is at 78% disability. The treating physician's listed diagnoses are: 1. Post cervical laminectomy syndrome. 2. Disk disorder, cervical spine. 3. Lumbar DDD. 4. Cervical radiculopathy. 5. Lumbar radiculopathy. The treating physician wanted to continue the patient on medications as, "They are alleviated somewhat by current medications". There is a report on 09/18/2013 by [REDACTED] [REDACTED] who indicates that the patient does have some symptoms of psychological overlay and that the patient was transferring care to another practice and that the patient would benefit from psychological treatment and pharmacological management in the future to hopefully help him assist with tapering of his narcotic medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

DIAZEPAM 5MG #60: Upheld

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

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

Decision rationale: This patient presents with chronic pain syndrome status post neck fusion surgery from 2001, status intrathecal pump placement on 04/20/2013. Request was diazepam 5 mg #30. Review of the reports show that the patient was taking Valium up to 30 mg a day back in 07/03/2013. This was slowly tapered, and the patient is currently down to 5 mg #30. MTUS Guidelines do not support the use of Valium for chronic pain. It states on page 24, "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence". Given that this patient has been prescribed Valium on a long-term basis and the lack of support in MTUS Guidelines, recommendation is for denial.

DILAUDID 8MG#30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANALGESICS, HYDROMORPHONE. Decision based on Non-MTUS Citation PAIN (CHRONIC)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, LONG-TERM ASSESSMENT Page(s): 88-89.

Decision rationale: This patient presents with chronic neck pain and chronic pain syndrome. The patient has had C-spine surgery in 2001 and intrathecal pump placed on 04/20/2013. There is a request for Dilaudid 8 mg to be used for breakthrough pain. MTUS Guidelines states regarding chronic opiate use, that pain assessment and function should be compared to baseline, and numeric scale showing functional change and pain assessment should be provided once every 6 months or use of validated instrument. In this case, there is no numeric scale used to denote this patient's function or pain. Review of the multiple reports including 10/15/2013, 08/22/2013, 07/22/2013, 07/03/2013 do not describe this patient's functional improvement with the use of intrathecal pump or the breakthrough pain. The patient is requesting more and more medications for breakthrough pain. Dilaudid has been slowly tapered from 8 mg 3 times a day down to 1 a day. There is no evidence based on all of the reports reviewed from 2013 that any of these opiates have helped improve this patient's chronic pain condition in terms of function, pain reduction, and improving quality of life. Without these documentations, ongoing use of opiates is not recommended. Recommendation in this was denial and further tapering of this medication per MTUS Guidelines.

SEROQUEL 200MG #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SEROQUEL, MENTAL ILLNESS & STRESS CHAPTER, ATYPICAL ANTIPSYCHOTICS.

Decision rationale: This patient presents with chronic pain syndrome with intrathecal pump placed on 04/20/2013. Patient had neck surgery in 2001. There is a request for Seroquel 200 mg #30. This is prescribed for patient's insomnia. While MTUS Guidelines and ACOEM do not address Seroquel, ODG Guidelines states that this is not recommended as a first-line treatment. In particular, it states under mental illness and stress chapter, "Antipsychotic drugs are commonly prescribed off-label for a number of disorders outside of their FDA approved indications, schizophrenia and bipolar disorder. In a new study funded by the National Institute of Mental Health, 4 of the anti-psychotics most commonly prescribed off-label for use in patients over 40 were found to lack both safety and effectiveness." One of these medications was Seroquel. It further states, "The authors concluded that often off-label use of these drugs in people over 40 should be short term and undertaken with caution." Given the lack of support from ODG Guidelines, recommendation is for denial.

PSYCHIATRIC CONSULTATION FOR EVALUATION AND TREATMENT:

Overtured

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS ACOEM GUIDELINES, CHAPTER 8 (NECK AND UPPER BACK COMPLAINTS).

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 127.

Decision rationale: This patient presents with chronic pain and psychological overlay. There is a request for psychiatric consultation and evaluation treatment. Patient has had psychiatric evaluation treatments. [REDACTED] report, 09/18/2013, recommends psychological treatments. The patient has switched care to [REDACTED], who has recommended psychiatric treatment. MTUS Guidelines support psychological evaluation and treatments. ACOEM Guidelines page 127 also supports specialty referrals. Recommendation is for authorization to address this patient's ongoing psychological issues