

Case Number:	CM13-0044311		
Date Assigned:	12/27/2013	Date of Injury:	01/26/1989
Decision Date:	04/24/2014	UR Denial Date:	10/03/2013
Priority:	Standard	Application Received:	10/28/2013

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 patient is a 56 year-old female with a 1/26/1989 industrial injury claim. She has been diagnosed with chronic low back pain; RSD in BUE and BLE; lumbar/thoracic radiculopathy; OA of the hips; Raynaud's syndrome; scar in neuroma; bilateral hip, hand, wrist pain; Carpal Tunnel Syndrome (CTS). According to the 9/18/13 pain management report from [REDACTED], the patient presents for monthly refills of pain medications for chronic mid to low back pain, bilateral hip pain, tailbone/buttock pain, RSD of upper and lower extremities, bilateral wrist and hand pain. She gets 20-25% improvement on average with medications. Pain is 9/10 without medications, 7/10 with medications. [REDACTED] provides a numeric value functional assessment showing 7/10 interference with relations with people, 9/10 interference with mood and general activity, 10/10 interference with walking, work and sleep.

IMR ISSUES, DECISIONS AND RATIONALES

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

PERCOCET: Overturned

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

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, regarding Opioid usage over six months states that the treating physician should document the following "...pain and functional improvement and compare to baseline. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." Based on the medical records provided for review, the 9/18/13 pain management report from [REDACTED], the patient presents for monthly refills of pain medications for chronic mid to low back pain, bilateral hip pain, tailbone/buttock pain, RSD of upper and lower extremities, bilateral wrist and hand pain. She gets 20-25% improvement on average with medications. Pain is 9/10 without medications, 7/10 with medications. [REDACTED] provides a numeric value functional assessment showing 7/10 interference with relations with people, 9/10 interference with mood and general activity, 10/10 interference with walking, work and sleep. Based on the medical records provided review the patient meets MTUS guidelines for this medication. The request for Percocet 5/325 PO Q6hrs PRN # 240 is medically necessary and appropriate.

CLONAZEPAM: Upheld

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

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

Decision rationale: According to the 9/18/13 pain management report from [REDACTED], the patient presents for monthly refills of pain medications for chronic mid to low back pain, bilateral hip pain, tailbone/buttock pain, RSD of upper and lower extremities, bilateral wrist and hand pain. The physician provides a pain and functional assessment using a numeric scale and discusses efficacy medications. MTUS guidelines states benzodiazepines are not recommended for long-term use, and states most guidelines limit use to 4-weeks. The medical records show the patient has been on clonazepam on 7/24/13, and it has been over the 4-week limit. The continued use of Clonazepam is not in accordance with MTUS recommendations. The request for Clonazepam is not medically necessary and appropriate.

MSIR, AND A COMPOUND PAIN CREAM SOLUTION THAT CONTAINS KETAMINE, CYCLOBENZAPRINE, GABAPENTIN, TRAMADOL, AMITRIPTYLINE AND CLONIDINE: Upheld

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

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

Decision rationale: The patient has chronic pain. The physician states the patient is using the compounded topical cream containing ketamine, cyclobenzaprine, gabapentin, tramadol, amitriptyline and clonidine, and she crushes two MSIR 15mg (oral tablets) into this or another skin cream. The California MTUS gives a general statement about compounded products: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The compound contains gabapentin and cyclobenzaprine, and MTUS guidelines specifically states that Gabapentin is not recommended for topical applications, and muscle relaxants are not recommended for topical applications, therefore any compounded product with these, are not recommended. The request for MSIR, compound pain cream solution that contains Ketamine, Cyclobenzaprine, Gabapentin, Tramadol, Amitriptyline and Clonidine is not medically necessary and appropriate.