

Case Number:	CM13-0046402		
Date Assigned:	12/27/2013	Date of Injury:	09/16/2013
Decision Date:	03/07/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	11/12/2013

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 Occupational Medicine 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:

The applicant is a represented [REDACTED] employee who has filed a claim for chronic low back pain, fibromyalgia, depression, and myofascial pain syndrome reportedly associated with an industrial injury of September 16, 2003. Thus far, the applicant has been treated with the following analgesic medications, attorney representation, transfer of care to and from various providers in various specialties, psychotropic medications, topical agents, trigger point injection therapy, unspecified amounts of acupuncture, physical therapy, and psychotherapy and extensive periods of time off of work. In a utilization review report of October 30, 2013, the claims administrator partially certified a request for OxyContin for weaning purposes, partially certified Roxicodone for weaning purposes, partially certified Baclofen for weaning purposes, partially certified Topamax for weaning purposes, partially certified Lidoderm for weaning purposes, and partially certified Desyrel and Cymbalta for weaning purposes. It is noted that the claims administrator's report was quite difficult to follow. An earlier note of October 10, 2013 is notable for comments that the applicant is having issues with chronic low back pain. She is depressed. She is on high doses of pain medications. She is a candidate for spinal cord stimulator and/or intrathecal pump. She is anxious, in marked distress, and is in pain even when sitting. She exhibits an antalgic gait with associated myofascial tenderness. The applicant's work status is not detailed, but it does not appear that she has returned to work. A later note of November 7, 2013 is notable for comments that the applicant is trying to taper off of OxyContin, Lunesta, and Intermezzo. An earlier note of August 7, 2013 is notable for comments that the applicant is having issues with situational depression and anxiety.

IMR ISSUES, DECISIONS AND RATIONALES

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

OxyContin 80mg TID: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Section Page(s): 80.

Decision rationale: As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful return to work, improved function, and/or reduced pain affected as a result of ongoing opioid usage. In this case, however, the aforementioned criteria have not been met. The applicant has seemingly failed to return to work. There is no evidence of reduced pain, improved function, and/or appropriate analgesia exhibited as a result of ongoing opioid usage. Continuing OxyContin, on balance, is not indicated. Therefore, the request is not certified.

Roxicodone 30mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Section Page(s): 80.

Decision rationale: As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful return to work, improved functioning, and/or reduced pain. In this case, however, the documentation on file does not establish the presence of improved functioning and/or reduced pain effected as a result of ongoing opioid usage. The applicant has seemingly failed to return to any form of work. The continuation of opioid therapy in this context is not indicated. Therefore, the request is not certified.

Baclofen 10mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Baclofen Section Page(s): 64.

Decision rationale: As noted on page 64 of the MTUS Chronic Pain Medical Treatment Guidelines, Baclofen is recommended orally in the treatment of spasticity and spasm associated with spinal cord injuries. In this case, however, the documentation on file does not establish the presence of spasticity and/or spasm associated with spinal cord injury. It is further noted that, as

with the other medications, that the applicant has failed to achieve any lasting benefit or functional improvement through prior usage of Baclofen. The applicant has failed to return to work. There is no evidence of reduced dependence on medical treatment. If anything, the fact that a spinal cord stimulator and/or intrathecal pump are being considered implies that previous usage of Baclofen and other analgesic and adjuvant medications was ineffective. Therefore, the request is not certified owing to a lack of functional improvement as defined in MTUS 9792.20f despite prior usage of Baclofen.

Topamax 200mg: Upheld

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

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

Decision rationale: As noted on page 21 of the California MTUS Chronic Pain Medical Treatment Guidelines, Topamax or Topiramate is considered for use for neuropathic pain when other anticonvulsants fail. In this case, however, as with the many other analgesic and adjuvant medications, the applicant has failed to profit from prior usage of Topamax or Topiramate. The fact that the applicant remains off of work, on total temporary disability, and remains highly reliant on various analgesic and adjuvant medications, taken together, implies a lack functional improvement as defined in MTUS 9792.20f. Therefore, the request for additional Topamax is not certified.

Lidoderm 5% 2 patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine Section Page(s): 112.

Decision rationale: While page 112 of the California MTUS Chronic Pain Medical Treatment Guidelines does tepidly support usage of Lidoderm patches or Lidocaine patches in the treatment of neuropathic pain which has proven recalcitrant to first line antidepressants and/or anticonvulsants, in this case, as with the numerous other oral and topical agents, the applicant has failed to demonstrate any functional improvement, lasting benefit, or profit through prior usage of Lidoderm patches. Therefore, the request is not certified.

Zofran 4mg: Upheld

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

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

Decision rationale: The California MTUS does not address the topic. As noted in the ODG chronic pain chapter antiemetics topic, Ondansetron or Zofran is FDA approved for gastroenteritis, for nausea or vomiting secondary to chemotherapy or radiation treatment, and for postoperative use purposes. In this case, however, there is no evidence that the applicant has had any recent surgery, chemotherapy, radiation therapy, etc. There is likewise no evidence of a recent bout of gastroenteritis present here. Therefore, the request for Zofran is not certified.

Intermezzo 3.5mg: Upheld

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

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

Decision rationale: Intermezzo, per the product description, represents a form of Ambien, a sleep aid. The California MTUS does not address the topic of Zolpidem or Intermezzo usage. As noted in the ODG chronic pain chapter Zolpidem topic, Zolpidem or Ambien is indicated in the short-term management of insomnia, typically on the order of two to six weeks. It is not recommended in the chronic, long-term, and/or scheduled use for which it is being proposed here. It is further noted that the attending provider has himself acknowledged that prior usage of Intermezzo has been ineffectual and has apparently taken plans to try and wean the applicant off of the same. For all of these reasons, then, the request is not certified.

Lunesta 3mg: Upheld

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

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

Decision rationale: The California MTUS does not address the topic. As noted in the ODG chronic pain chapter insomnia treatment topic, Lunesta is the only benzodiazepine receptor agonist which is FDA approved for usage greater than 35 days. In this case, however, as with the numerous other analgesic and adjuvant medications, the applicant has failed to achieve any lasting benefit or functional improvement through prior usage of Lunesta. The attending provider has written that this particular medication has been ineffectual. Therefore, the request is likewise not certified.

Trazodone 50mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 402.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in chapter 15, antidepressants may take several weeks to exert their maximal effect. In this case, the applicant is apparently having ongoing issues with depression, anxiety, and insomnia, making Trazodone a particularly appropriate choice. The attending provider has written that he intends to employ Trazodone at a heightened dose while discontinuing the other sleep aids. This is indicated, given the multiplicity of mental health symptoms reported here. Therefore, the request is certified, on independent medical review.