

Case Number:	CM13-0065040		
Date Assigned:	01/03/2014	Date of Injury:	03/01/2003
Decision Date:	03/28/2014	UR Denial Date:	12/03/2013
Priority:	Standard	Application Received:	12/12/2013

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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 66 yo female who sustained a work injury on 03/01/2003. The mechanism of injury was described as repetitive movements related to her job duties. Her diagnoses include cervical disc disease with radiculopathy and carpal tunnel syndrome. She continues to complain of neck pain with radiation to both hands. On exam there is decreased cervical range of motion with palpable spasm in the paraspinal and trapezius muscles. There is pain with range of motion of the wrists with numbness in the fingers. Treatment has included medical therapy, evaluations by pain management and physiatry, and pool therapy. The treating provider has requested Lyrica 75mg #90, Cymbalta 30 #60, Ultram 50mg #60, and Vicoprofen 7.5/200mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ninety (90) Capsules of Lyrica 75 mg: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 15, 20.

Decision rationale: The Physician Reviewer's decision rationale: The requested medication, Lyrica is medically necessary for the treatment of the patient's condition. Per the documentation she has neuropathic pain related to her chronic neck condition. The medication is part of her medical regimen and per California MTUS Guidelines 2009 antiepilepsy medications are a first line treatment for neuropathic pain. Lyrica is FDA approved for diabetic neuropathy and post-herpetic neuralgia and has been used effectively for the treatment of neuropathic pain. The patient has reported a reduction in her pain with the medical therapy which would be defined as a 50% reduction which would represent a "good " response. Medical necessity has been established and the requested treatment is medically necessary for treatment of the patient's chronic pain condition.

Sixty (60) capsules of Cymbalta 30 mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-15.

Decision rationale: Duloxetine (sold under the brand names Cymbalta, Aricclaim, Xeristar, Yentreve, Duzela, Dulane) is a serotonin norepinephrine reuptake inhibitor. It is prescribed for major depression and generalized anxiety disorder (GAD). Duloxetine also has approval for use in osteoarthritis and musculoskeletal pain. The documentation indicates the claimant has chronic pain condition with associated radiculopathy. Antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Medical necessity for the requested item has been established. The requested item is medically necessary.

Sixty (60) tablets of Ultram 50 mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93, 94-96.

Decision rationale: The review of the medical documentation indicates that the requested medication, Ultram is not medically necessary and indicated for the treatment of the claimant's chronic pain condition. Per California MTUS, Ultram (Tramadol) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there has been no documentation of the medication's pain relief effectiveness and

no clear documentation that he has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. Medical necessity for the requested item has not been established. The requested treatment is not medically necessary.

Vicoprofen 7.5/200 mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91-97.

Decision rationale: The drug combination hydrocodone/ibuprofen (trade name Vicoprofen) is an analgesic medication used in short-term therapy to relieve severe pain. Per California MTUS Guidelines, short-acting opioids are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. Per the medical documentation there has been no documentation of the medication's pain relief effectiveness and no clear documentation that she has responded to ongoing opioid therapy. According to the California MTUS Guidelines there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred with this patient. The patient has continued pain despite the continued use of short acting opioid medications and has decreased renal function which requires avoidance of nonsteroidal anti-inflammatory medications such as ibuprofen. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.