

Case Number:	CM13-0065163		
Date Assigned:	01/03/2014	Date of Injury:	03/31/2004
Decision Date:	08/06/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/12/2013

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 Pain Medicine licensed to practice in 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 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 injured worker is a 61 year old female injured on 08/31/04 due to an undisclosed mechanism of injury. Current diagnoses include lumbar radiculopathy, chronic pain syndrome, chronic pain related insomnia, myofascial syndrome, neuropathic pain, prescription narcotic dependence, chronic pain related depression and tension headaches. Clinical note dated 11/25/13 indicated the injured worker presented complaining of anterior right shoulder pain worsening with cold weather. The injured worker reports use of topical ointment has helped with discomfort. The injured worker reports pain score as 4-5/10 with medication and 10/10 without. The injured worker reports average pain as 6-7/10. Urine drug screen report on 11/04/13 was positive for venlafaxine, oxymorphone, cyclobenzaprine, and negative for prescribed Trazodone. Current medications include Opana ER 40mg vid, Opana IR 10mg three times a day, lidoderm 5% q12 hours, Trazodone 50mg 2 tablets every night, Pristiq 50mg every day, Flexeril 10mg three times a day, Kava-Kava three times a day, Cidaflex three times a day, Prilosec 20mg every day, Sintralyne 1-2 tablets every night and Keto/Gaba/Lido ointment three times a day. The initial request for Opana ER 40mg #60, Opana IR 10mg #120, Pristiq 50mg #30, topical compound Keto/Gaba/Lido ointment, and Sintralyne #60 was initially non-certified on 12/05/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

OPANA ER 40MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: Patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. In addition, recent urine drug screen reports indicated inconsistent findings based on prescribed medications which was not addressed in the clinical documentation. Further, current guidelines indicate opioid dosing should not exceed 100mg morphine equivalent dosage/day; the injured worker current morphine equivalent dosage is 360mg/day. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Opana ER 40mg #60 cannot be established at this time. Given the above the request is not medically necessary.

OPANA IR 10MG #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: Patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. In addition, recent urine drug screen reports indicated inconsistent findings based on prescribed medications which was not addressed in the clinical documentation. Further, current guidelines indicate opioid dosing should not exceed 100mg morphine equivalent dosage/day; the injured worker current morphine equivalent dosage is 360mg/day. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of Opana IR 10mg #120 cannot be established at this time. However, due to the nature of this drug, weaning is necessary. Given the above the request is not medically necessary.

PRISTIQ 50MG #30: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 388.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SNRIs (serotonin noradrenaline reuptake inhibitors) Page(s): 105.

Decision rationale: Serotonin norepinephrine reuptake inhibitors are recommended as an option in first-line treatment of neuropathic pain, especially if tricyclics are ineffective, poorly tolerated, or contraindicated. It is noted in the documentation that the injured worker also requires Pristiq for the treatment of ongoing symptoms associated with depression. As such, the request for Pristiq 50MG #30 is recommended as medically necessary.

TOPICAL COMPOUND KETO/GABA/LIDO OINTMENT: Upheld

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

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

Decision rationale: The safety and efficacy of compounded medications has not been established through rigorous clinical trials. California Medical Treatment Utilization Schedule, Food and Drug Administration and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. This compound contains both ketoprofen and gabapentin which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore topical compound ketoprofen/gabapentin/lidocaine ointment cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

SINTRALYNE #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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), Herbal medicines.

Decision rationale: As noted in the Pain chapter of the Official Disability Guidelines - Online version, the use of herbal medicines or medical foods is not recommended. Additionally, there is no indication the injured worker has failed previous prescription medications or has obvious contraindications that necessitate medical food/herbal use. Further, there is no indication that the injured worker cannot utilize the over-the-counter version of this medication. Moreover, resources list depression as a contraindication for the use of sintralyne which is a diagnosis that is currently being treated. As such, the request for Sintralyne #60 is not medically necessary.