

Case Number:	CM13-0068520		
Date Assigned:	01/03/2014	Date of Injury:	07/31/2002
Decision Date:	04/21/2014	UR Denial Date:	11/11/2013
Priority:	Standard	Application Received:	12/19/2013

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, and is licensed to practice in Illinois. 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 57-year-old who reported an injury on July 31, 2012. The mechanism of injury was not stated. The patient is currently diagnosed with cervical pain, cervical radiculopathy, cervical disc disorder, and shoulder pain. The patient was seen by [REDACTED] on November 13, 2013. The patient reported persistent neck and left upper extremity pain. The patient also reported poor sleep quality. Current medications include flexeril, Celebrex, Nucynta, trazodone, aspirin, ibuprofen, levothyroxine, and Tylenol extra strength. Physical examination revealed restricted cervical range of motion, hypertonicity, spasm, tenderness to palpation, trigger points with a twitch response, positive Spurling's maneuver, trigger points with radiating pain and a twitch response in the lumbar spine, limited left shoulder range of motion, positive Neer and Hawkins testing, positive crossover testing, positive empty can testing, decreased strength in the left shoulder, and decreased sensation. Treatment recommendations at that time included continuation of current medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

NUCYNTA: 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) Chronic Pain Chapter, Tapentadol (Nucynta®) Section.

Decision rationale: The Official Disability Guidelines state Nucynta is recommended as second-line therapy for patients who develop intolerable adverse effects with first-line opioids. The patient does not appear to meet criteria for the requested medication. There is no documentation of intolerable adverse effects with first-line opioids. Additionally, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain with poor sleep quality and activity limitation. The request for Nucynta is not medically necessary or appropriate.

TRAZODONE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Trazodone (Desyrel) Section.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state anti-depressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Official Disability Guidelines state trazodone is recommended as an option for insomnia, only for patients with potentially co-existing mild psychiatric symptoms such as depression or anxiety. As per the documentation submitted, there is no evidence of depressive or anxious symptoms. Additionally noted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report poor sleep quality. There is also no indication of a failure to respond to non-pharmacologic treatment prior to the initiation of a prescription product. The request for Trazodone is not medically necessary or appropriate.

CELEBREX: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state NSAIDs (non-steroidal anti-inflammatory drugs) are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. Celebrex is used for the relief of the signs and symptoms of osteoarthritis, rheumatoid arthritis, and ankylosing spondylitis. According to the documentation submitted, the patient does not maintain a diagnosis of osteoarthritis, rheumatoid arthritis, or ankylosing spondylitis. It is additionally noted that the patient has continuously utilized this medication. Despite ongoing use, the patient continues to

report persistent pain, poor sleep quality, and activity limitation. There is no documentation of a significant change in the patient's physical examination that would indicate functional improvement. The request for Celebrex is not medically necessary or appropriate.

FLEXERIL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state muscle relaxants are recommended as non-sedating second-line options for short-term treatment of acute exacerbations. Flexeril should not be used for longer than two to three weeks. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. The patient's physical examination continues to reveal palpable muscle spasm with multiple trigger points. As guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. The request for Flexeril is not medically necessary or appropriate.

LUNESTRA: 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) Chronic Pain Chapter, Insomnia Treatment Section.

Decision rationale: Official Disability Guidelines state insomnia treatment is recommended based on etiology. Lunesta has demonstrated reduced sleep latency and sleep maintenance. According to the documentation submitted, the patient was instructed to discontinue Lunesta in October of 2013, secondary to adverse effects. There is no documentation of this patient's current utilization of this medication. The request for Lunesta is not medically necessary or appropriate.