MAXIMUS Federal Services

Case Number:	CM13-0070742		
Date Assigned:	01/08/2014	Date of Injury:	09/17/2001
Decision Date:	06/05/2014	UR Denial Date:	12/06/2013
Priority:	Standard	Application Received:	12/26/2013

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 and is 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 54-year-old male who reported an injury on 09/17/2001. The mechanism of injury was not stated. Current diagnoses include post laminectomy pain syndrome, chronic pain syndrome, adult onset diabetes mellitus, hypertension, history of C7 spinous process fracture, medication induced constipation, reactive depression and sexual dysfunction. The injured worker was evaluated on 12/30/2013. The injured worker reported increasing weakness throughout bilateral lower extremities. Physical examination revealed tenderness to palpation of bilateral shoulders and cervical spine, and 3/5 strength in the quadriceps, extensor hallucis longus and gastrocnemius bilaterally. Treatment recommendations included continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE PRESCRIPTIONOF NUCYNTA 75MG: Upheld

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

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).

Decision rationale: Official Disability Guidelines state Nucynta is recommended as a second line option for patients who develop intolerable adverse effects with first line opioids. The injured worker does not meet criteria as outlined by the Official Disability Guidelines for the use of this medication. There is not documentation of intolerable adverse effects with first line opioids. There is also no frequency or quantity listed in the current request. As such, the request is not medically necessary.

ONE PRESCRIPTION OF CYMBALTA 60MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: Chronic Pain Medical Treatment Guidelines state Cymbalta is FDA approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. The injured worker has utilized Cymbalta 60 mg since 06/2013. The injured worker continues to report persistent symptoms. There is no evidence of objective functional improvement. There is also no frequency or quantity listed in the current request. As such, the request is not medically necessary.

ONE PRESCRIPTION OF CIALIS 20MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Urological Assocation Education And Research.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation U.S. National Library of Medicine. U.S. Department of Health and Human Services National Institutes of Health. Updated: 24 April 2014, Tadalafil (Cialis).

Decision rationale: Cialis is used to treat erectile dysfunction, impotence, and symptoms of benign prostatic hyperplasia which include difficulty urinating, painful urination, and urinary frequency. The injured worker does maintain a diagnosis of sexual dysfunction; however, the injured worker has utilized Cialis 20 mg since 07/2013 without any evidence of functional improvement. There is also no frequency or quantity listed in the current request. As such, the request is not medically necessary.

ONE PRESCRIPTION OF AMBIEN 10MG: Upheld

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

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.

Decision rationale: Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. There is no documentation of chronic insomnia or sleep disturbance. There is also no frequency or quantity listed in the current request. As such, the request is not medically necessary.

ONE PRESCRIPTION OF FLECTOR PATCH 1.3%: Upheld

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

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

Decision rationale: Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The only FDA approved topical (NSAID) non-steroidal anti-inflammatory drugs is Diclofenac which is indicated for the relief of osteoarthritis pain. It has not been evaluated for treatment of the spine, hip or shoulder. Therefore, the current request cannot be determined as medically appropriate. There is also no frequency or quantity listed in the current request. As such, the request is not medically necessary.