

Case Number:	CM14-0000127		
Date Assigned:	01/10/2014	Date of Injury:	02/18/2009
Decision Date:	07/02/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	12/31/2013

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 & Rehabilitation 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 52-year-old male who reported an injury on 02/18/2009, due to cumulative trauma while performing normal job duties. The injured worker's treatment history included multiple surgical interventions, a brain injury treatment program, physical therapy and multiple medications. The injured worker was evaluated on 12/19/2013. It was documented that the injured worker had decreased range of motion of the lumbar spine secondary to pain, cervical spine range of motion limited due to stiffness, and moderate to severe left hip pain with tenderness and spasming of the sacroiliac joint. The injured worker's treatment plan included continuation of medication and a left sacroiliac joint injection. The injured worker's medications included Lunesta 3 mg, Cymbalta 60 mg, Gralise 600 mg, Percocet 10/325 mg, Naprelan 750 mg #30, Prilosec 20 mg, Amrix 15 mg, Pamelor 10 mg, and Viagra 100 mg. The injured worker was again evaluated on 01/17/2014. It was documented that Percocet allowed the injured worker to participate in prolonged activities, Amrix reduced muscle spasming and increased ability to participate in a home exercise program, Naprelan reduced swelling in the shoulder, dyspepsia was well controlled with Prilosec and diet, Gralise decreases stump pain by 60% allowing him to use his prosthesis, Viagra allowed him and his fiancé to be intimate for the first time without struggling in over a year, Lunesta allowing the injured worker to sleep for 4 straight hours to improve next day function, Pamelor to decrease nighttime depression and chronic pain symptoms, and Cymbalta to decrease his low back pain. An additional request was made to refill medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

PERCOCET 10 MG #150: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested Percocet 10 mg #150 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of opioids in management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, evidence that the injured worker is monitored for aberrant behavior, and managed side effects. The clinical documentation submitted for review does indicate that the injured worker is engaged in an opioid contract and does not exhibit any symptoms of aberrant behavior. Additionally, it is noted that this medication allows for improved function and a reduction in pain. However, the request as it is submitted does not clearly define a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Percocet 10 mg #150 is not medically necessary or appropriate.

PAMELOR 10 MG: 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain Page(s): 12.

Decision rationale: The requested Pamelor 10 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend antidepressants in the ongoing management of chronic pain. The clinical documentation does indicate that the injured worker takes this medication to reduce depression related symptoms caused by chronic pain. California Medical Treatment Utilization Schedule recommends that all medications used in the management of chronic pain be supported by documentation of functional benefit and evidence of pain relief. The clinical documentation does indicate that the injured worker's medications allow for improved function; however, the request as it is submitted does not clearly identify a quantity or duration of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Pamelor 10 mg is not medically necessary or appropriate.

AMRIX 15 MG #30: Upheld

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

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

Decision rationale: The requested Amrix 10 mg #150 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the long-term use of muscle relaxants in the management of chronic pain. California Medical Treatment Utilization Schedule recommends short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation does indicate that the injured worker has been on this medication since at least 08/2013. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Amrix 15 mg #30 is not medically necessary or appropriate.

PRILOSEC 20 MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs, Gastrointestinal Symptoms & Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The request Prilosec 20 mg #30 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the ongoing use of gastrointestinal protectants be supported by documentation that the injured worker is at continued risk for development of gastrointestinal symptoms related to medication usage. The clinical documentation submitted for review does indicate that the injured worker has well controlled gastrointestinal upset with the use of this medication in combination with a controlled diet. However, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Prilosec 20 mg #30 is not medically necessary or appropriate.

NAPRELAN 750 MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs.

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

Decision rationale: The requested Naprelan 750 mg #30 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the long-term use of muscle relaxants in the management of chronic pain. California Medical Treatment Utilization Schedule recommends short durations of treatment not to exceed 2 to 3 weeks for acute exacerbations of chronic pain. The clinical documentation does indicate that the injured worker has been on this medication since at least 08/2013. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of

treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Naprelan 750 mg # 30 is not medically necessary or appropriate.

CYMBALTA 60 MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain Page(s): 12.

Decision rationale: The requested Cymbalta 60 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend antidepressants in the ongoing management of chronic pain. The clinical documentation does indicate that the injured worker takes this medication to reduce depression related symptoms caused by chronic pain. California Medical Treatment Utilization Schedule recommends that all medications used in the management of chronic pain be supported by documentation of functional benefit and evidence of pain relief. The clinical documentation does indicate that the injured worker's medications allow for improved function; however, the request as it is submitted does not clearly identify a quantity or duration of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Cymbalta 60 mg #60 is not medically necessary or appropriate.

LUNESTA 3 MG #30: 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).

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

Decision rationale: The requested Lunesta 3 mg #30 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines do recommend this medication for long-term usage of insomnia related chronic pain. The clinical documentation does indicate that the injured worker received 4 hours of consistent sleep which aids in next day functional benefit. However, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Lunesta 3 mg #30 is not medically necessary or appropriate.

6 COGNITIVE BEHAVIORAL THERAPY SESSIONS WITHIN STATE FUND'S MPN:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Therapy Page(s): 23.

Decision rationale: The requested 6 cognitive behavioral therapy sessions within state fund's MPN is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends continued cognitive behavioral therapy be based on documented functional improvement of previous treatment. The clinical documentation submitted for review does indicate that the injured worker has had extensive cognitive behavioral therapy. Therefore, the need for additional cognitive behavioral therapy would not be indicated. As such, the requested 6 cognitive behavioral therapy sessions within state fund's MPN is not medically necessary or appropriate.

1 FOLLOW UP: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 405.

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

Decision rationale: The requested 1 follow-up is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not specifically identify or address the need for office visits. Official Disability Guidelines recommend follow-up visits for injured workers who are being treated for chronic pain. However, the request as it is submitted does not clearly identify what the follow-up visit is for. There are no goals of treatment or information to support the request. As such, the requested 1 follow-up is not medically necessary or appropriate.