

Case Number:	CM14-0001926		
Date Assigned:	01/24/2014	Date of Injury:	12/06/2001
Decision Date:	06/26/2014	UR Denial Date:	12/12/2013
Priority:	Standard	Application Received:	01/06/2014

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 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 injured worker is a 46 year old female with an injury reported on 12/06/2001. The mechanism of injury was not provided within the provided documentation. The clinical note dated 12/30/2013 reported that the injured worker complained of instability with increased neck pain. Upon physical examination, the injured worker had moderate left upper extremity weakness. It was noted a recent cervical spine MRI revealed C6-7 moderate disc protrusion with stenosis. It was also noted that an EMG revealed chronic left C6 radiculopathy. The injured worker's diagnoses included left cervical radiculopathy and cervical discogenic disease; status post lumbar spine laminectomy in March 2013; bilateral carpal tunnel syndrome; depressive disorder. The provider requested nucynta ER 100mg, norco 10/325mg, nortriptyline 10mg, valium 10mg, and biofreeze gel. The request for authorization was submitted on 12/30/2013. The provider's rationale for the request was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION OF NUCYNTA ER 100MG: 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 Opioids, criteria for use Page(s): 78. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Tapentadol (Nucynta_®).

Decision rationale: The request for 1 prescription of nucynta er 100mg is not medically necessary. The injured worker complained of instability with increased neck pain. The injured worker has moderate left upper extremity weakness. It was noted a recent cervical spine MRI revealed C6-7 moderate disc protrusion with stenosis. The California MTUS guidelines recognize four domains that have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids to include pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. According to the Official Disability Guidelines, Nucynta is recommended as a second line therapy for patients who develop intolerable adverse effects with first line opioids. There is a lack of information provided documenting the efficacy of the Nucynta as evidenced by decreased pain and significant objective functional improvements. Furthermore, the requesting provider did not specify the quantity or the frequency being requested. Therefore, the request is not medically necessary.

1 PRESCRIPTION OF NORCO 10/325MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS FOR CHRONIC PAIN, OPIOIDS, CRITERIA FOR USE,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, Opioids criteria for use, On-Going Management Page(s): 91, 76-78.

Decision rationale: The request for 1 prescription of norco 10/325mg is not medically necessary. The injured worker complained of instability with increased neck pain. It was reported the injured worker has moderate left upper extremity weakness. It was noted a recent cervical spine MRI revealed C6-7 moderate disc protrusion with stenosis. The California MTUS guidelines recognize norco as a short-acting opioid, which is an effective method in controlling chronic pain. The guidelines recognize four domains that have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. There is a lack of information provided documenting the efficacy of the medication as evidenced by decreased pain and significant objective functional improvements. Furthermore, the requesting provider did not specify the quantity or the frequency being requested. Therefore, the request is not medically necessary.

1 PRESCRIPTION OF NORTRIPTYLINE 10MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES (2009), ANTIDEPRESSANTS,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13, 15.

Decision rationale: The request for 1 prescription of nortriptyline 10mg is not medically necessary. The injured worker complained of instability with increased neck pain. It was reported the injured worker has moderate left upper extremity weakness. It was noted a recent cervical spine MRI revealed C6-7 moderate disc protrusion with stenosis. Nortriptyline is classified as a Tricyclic antidepressant. The California MTUS guidelines recommend tricyclic antidepressants over selective serotonin reuptake inhibitors (SSRIs), unless adverse reactions are a problem. There is a lack of information provided documenting the efficacy of the medication as evidenced by decreased pain and significant objective functional improvements. Furthermore, the requesting provider did not specify the quantity or the frequency being requested. Therefore, the request is not medically necessary.

1 PRESCRIPTION OF VALIUM 10MG: 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 Benzodiazepines Page(s): 24.

Decision rationale: The request for 1 prescription of valium 10mg is not medically necessary. The injured worker complained of instability with increased neck pain. It was reported the injured worker has moderate left upper extremity weakness. It was noted a recent cervical spine MRI revealed C6-7 moderate disc protrusion with stenosis. The California MTUS guidelines do not recommend benzodiazepines for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. It was unclear how long the injured worker has been prescribed the medication. In addition, there is a lack of information provided documenting the efficacy of the medication as evidenced by decreased pain and significant objective functional improvements. Furthermore, the requesting provider did not specify the quantity or the frequency being requested. Therefore, the request is not medically necessary.

1 PRESCRIPTION OF BIOFREEZE GEL #1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES (2009), BIOFREEZE® CRYOTHERAPY GEL,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Biofreeze cryotherapy gel.

Decision rationale: The request for 1 prescription of biofreeze gel #1 is not medically necessary. The injured worker complained of instability with increased neck pain. It was reported the injured worker has moderate left upper extremity weakness. It was noted a recent cervical spine MRI revealed C6-7 moderate disc protrusion with stenosis. The Official Disability Guidelines recommend biofreeze as an optional form of cryotherapy for acute pain. There is a lack of information provided documenting the efficacy of the medication as evidenced by decreased pain and significant objective functional improvements. Furthermore, the requesting provider did not specify the quantity being requested. Therefore, the request is not medically necessary.