

Case Number:	CM14-0006790		
Date Assigned:	02/07/2014	Date of Injury:	10/23/2002
Decision Date:	06/10/2014	UR Denial Date:	01/02/2014
Priority:	Standard	Application Received:	01/15/2014

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 and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 51 year old female who sustained an injury on 10/23/02; however, no specific mechanism of injury was noted. The patient was followed for chronic complaints of low back pain radiating to the lower extremities and neck pain radiating to the upper extremities. Multiple medications included Lidoderm patches, glucosamine, Celebrex, Thermacare heat wrap, Ambien, Naprosyn, Neurontin, Pantoprazole, Robaxin, Maxalt, Zoloft, Zofran, Percocet, and Xanax have been utilized. The most recent laboratory results for the patient were from 07/15/13 which noted positive results for benzodiazepines. No other positive findings were noted. Pain scores were rated at 8/10 on VAS as of 11/13. The most recent evaluation on 12/26/13 reported no substantial changes in pain. Some minimal improvement with pain medications was noted. The patient was pending a psychiatric evaluation for a spinal cord stimulator trial. On physical examination there was tenderness to palpation bilaterally in the paravertebrals with limited range of motion in the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

THERAMACARE HEATWRAP #24: 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: Neck & Upper Back Chapter, Hot/Cold Packs.

Decision rationale: There was no indication from that the patient was receiving any substantial functional benefit with the use of a heat wrap for the cervical spine. Given that the heat wraps were commercially available over the counter and did not require prescriptions, there was no rationale provided for a prescription level heat wrap for chronic musculoskeletal complaints. Therefore, the request for Thermacare heat wrap # 24 is not medically necessary and appropriate.

CELEBREX 200 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 68.

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines anti-inflammatories such as Celebrex were not recommended for chronic long term use. In this case, there was no indication from the clinical records that the patient was suffering from any recent acute exacerbation or flare up of chronic musculoskeletal symptoms to support the use of Celebrex. Given the risk factors involved with long term use of anti-inflammatories including liver, kidney and cardiac complications the request cannot be supported. The request for Celebrex 200 mg, #60 is not medically necessary and appropriate.

LIDODERM 5% PATCH #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LIDODERM (LIDOCAINE PATCH) Page(s): 57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LIDODERM Page(s): 56.

Decision rationale: Lidoderm patches are indicated in the treatment of neuropathic pain when there had been a failure of other first line medications to address neuropathic pain such as antidepressants or anticonvulsants. It was unclear from the clinical records whether the patient had failed a reasonable trial of first line antidepressants or anticonvulsants. Furthermore, the most recent physical examination findings identified musculoskeletal complaints only, without evidence of any focal neurological deficits to support ongoing neuropathic symptoms which would require the use of this medication. Therefore, the request for Lidoderm 5% patch, #30 is not medically necessary and appropriate.

PERCOCET 10-325 MG #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 88-89.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, regarding the criteria for use of opioids, "1) Re-assess (a) has the diagnosis changed? (b) What other medications is the patient taking? Are they effective, producing side effects? (c) What treatments have been attempted since the use of opioids? Have they been effective? For how long? (d) Document pain and functional improvement and compare to baseline. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. (e) Document adverse effects: constipation, nausea, vomiting, headache, dyspepsia, pruritis, dizziness, fatigue, dry mouth, sweating, hyperalgesia, sexual dysfunction, and sedation. (f) Does the patient appear to need a psychological consultation? Issues to examine would include motivation, attitude about pain/work, return-to-work, social life including interpersonal and work-related relationships. (g) Is there indication for a screening instrument for abuse/addiction? See Substance Abuse Screening." From the clinical records provided for review reflected limited evidence regarding efficacy of Percocet in regards to pain reduction or functional improvement. The patient only reported a mild, two point decrease in pain levels with the entire medication regimen currently being prescribed. Furthermore, there was noted inconsistency in the toxicology results. The last toxicology result from 07/13 noted positive findings for un-prescribed benzodiazepine only. The request for Percocet 10-325 mg # 120 is not medically necessary and appropriate.