

Case Number:	CM14-0105540		
Date Assigned:	08/11/2014	Date of Injury:	01/25/2001
Decision Date:	10/16/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/08/2014

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 Nevada. 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 68-year-old female who was reportedly injured on January 25, 2001. The most recent progress note dated August 14, 2014, indicated that there were ongoing complaints of low back pain. The physical examination demonstrated a 5'1", 145 pound individual who was normotensive (124/53). The injured worker was described as being in no acute distress, responded accordingly and assisted comfortably. A steady gait was reported and emulation requires a wheeled walker. There was some tenderness to palpation of the paraspinous musculature. A reduced lumbar spine range of motion was noted. The lumbar surgical scars were noted to be well healed. Diagnostic imaging studies objectified postsurgical changes. Previous treatment included multiple lumbar surgeries, multiple medications, multiple rehabilitation attempts, physical therapy and other pain management interventions. A request was made for multiple medications and was not certified in the pre-authorization process on June 17, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective review of Oxycodone HCL 150 mg #150 DOS 1-4-13, 2-8-13, 4-8-13, 9-6-13, 10-3-13, 11-29-13, 1-6-14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74, 78, 93.

Decision rationale: As outlined in the MTUS, there is support for short acting opioids in the short-term management of moderate to severe breakthrough pain. However, the progress notes, presented for review, do not indicate any substantive gains with the use of this medication. The pain complaints are unchanged. The blood pressure levels are also unchanged, and there is simply no documentation presented to suggest the need for a chronic opioid analgesic. Therefore, based on the clinical information presented for review, this request is not medically necessary.

Retrospective review of Fentanyl 100 mcg/hr patch #15 (DOS: 01-04-13, 2-8-13, 1-6-14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74, 78, 93.

Decision rationale: When reviewing the progress notes over the last year, the overall clinical situation appear to be relatively stable. Blood pressure was normotensive. Pulse rate was 61, and there was simply no indication of a need for a chronic pain that is noted be 80 times stronger than morphine. As noted in the MTUS, this medication is not recommended for musculoskeletal pain. Therefore, based on the clinical evidence presented for review and by the parameters noted in the MTUS, this request is not medically necessary.

Retrospective use of Sumatriptan Succinate 100 mg #9 (DOS: 1-12-13, 6-10-13, 7-9-13, 1-6-14): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) headache updated August 2014

Decision rationale: It was noted that this is not addressed in the MTUS or the ACOEM guidelines. The parameters for chronic headache as noted in the Official Disability Guidelines (ODG) were applied. The progress notes, reviewed, do not indicate any indication of a migraine headache or similar malady. Therefore, there is insufficient clinical data presented to support the medical necessity of this medication. As such, this request is not medically necessary.

Retrospective review of Celebrex 100 mg#30 (DOS 12-13-13 and 1-6-14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22, 30, 70.

Decision rationale: As noted in the MTUS, there is specific recommendation for Cox II inhibitor type non-steroidal medications. It is also noted that this is an individual who has undergone lumbar surgery and has a reported post laminectomy syndrome. However, the clinical records do not support the need for a non-steroidal medication of this category. Therefore, based on the lack of clinical information, this request is not medically necessary.

Retrospective review of Lidoderm 5% patch #30 (DOS: 5-13-13, 9-27-13, 1-6-14): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines, Drug Formulary

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

Decision rationale: MTUS guidelines support the use of topical lidocaine for individuals with neuropathic pain that have failed treatment with first-line therapy including antidepressants or anti-epileptic medications. Based on the clinical documentation provided, the injured worker continues to have complaints of low back pain. The progress notes also do not reflect that this particular medication is successful in ameliorating the symptomatology relative to the neuropathic pain generator. As such, the request is medically necessary.

Retrospective review of Trazodone 100 mg #75 (DOS: 7-10-13, 1-6-14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chronic Pain: Clinical Measures; Medications-Antidepressants (Electronically Cited)

Decision rationale: Trazodone (Desyrel) is an antidepressant of the serotonin antagonists and reuptake inhibitor with anti-anxiety and sleep-inducing effects. MTUS/ACOEM practice guidelines do not support Trazodone for treatment of chronic persistent pain without depression. Review of the available medical records fails to document a diagnosis of depression. As such, this request is not medically necessary.

Retrospective review of Cymbalta 60 mg #30 (DOS: 1-23-11, 7-10-13, 1-6-14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 105.

Decision rationale: As outlined in the MTUS, this medication is supported for the use of neuropathic pain. However, there is nothing in the progress notes to suggest that this medication has been successful in achieving its intended goals of ameliorating the neuropathic pain generator sequelae. As such, this request is not medically necessary.

Retrospective use of an aluminum folding cane (DOS 9-24-12): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004): Knee disorders: clinical measures-devices (electronically cited)

Decision rationale: As outlined in the ACOEM guidelines, such devices are recommended if there is acute pain or clinical evidence. It was also noted that the injured employee was using a wheeled walker. There is no data presented to suggest why this device cannot be employed. As such, this request is not medically necessary.

Retrospective review of Single post adjustable cane (DOS 8-16-12): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004): Knee disorders: clinical measures-devices (electronically cited)

Decision rationale: As outlined in the ACOEM guidelines, such devices are recommended if there is acute pain or clinical evidence. It is also noted that the injured worker was using a wheeled walker. There is no data presented to suggest why this device cannot be employed. As such, this request is not medically necessary.

Retrospective of bathtub seat: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Knee chapter, updated September 2014

Decision rationale: This particular device is not addressed in the ACOEM or MTUS guidelines. The parameters noted in the Official Disability Guidelines (ODG) were employed. These are considered a comfort and convenience item; therefore, this request is not medically necessary.