

Case Number:	CM14-0012339		
Date Assigned:	02/21/2014	Date of Injury:	10/02/2010
Decision Date:	08/06/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	01/30/2014

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 Occupational 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 54-year-old female who has filed a claim for lumbosacral disc degeneration associated with an industrial injury date of October 02, 2010. Review of progress notes indicates pain to the neck, low back, left buttock, and entire back of the left thigh. Findings include diffuse tenderness of the spine. Treatment to date has included physical therapy, medial branch blocks, rhizotomy, chiropractic therapy, cognitive behavioral therapy, antidepressants, opioids, NSAIDs, Lyrica, and topical analgesic creams. Utilization review from January 17, 2014 denied the requests for Celebrex 200mg #30 as there was no documentation that the patient has reached any goals on this medication; Pristiq 200mg #30 as there was no documentation of efficacy, and there is no documentation regarding the reason for increasing the dosage; Topamax 25mg #42 as this medication is not indicated for painful radiculopathy; flurbiprofen/ketamine HCl/cyclobenzaprine/gabapentin/lidocaine/prilocaine/lipoderm cream 90 day supply + 1 refill as guidelines do not support the use of this medication; H-wave unit as there was no documentation of use of TENS; and transportation to/from medical visits as this is not a medical service for the relief or cure of an industrial injury. There was modified certification for Percocet 10/325mg for #100 as there was no documentation of improvement, and weaning was initiated.

IMR ISSUES, DECISIONS AND RATIONALES

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

PERCOCET 10-325 MG, #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; On-Going Management Page(s): 78-82.

Decision rationale: As noted on pages 78-82 of the CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Patient has been on this medication since at least April 2011. The requesting physician notes that this patient has not been using this medication consistently since, as this has not been authorized multiple times in the past, and thus there is no improvement of patient's condition. However, there is no documentation of the patient's recent or current symptoms and examination findings in the progress notes provided for review. There is no assessment of efficacy or response to previous treatment, absence of side effects. Therefore, the request for Percocet 10-325mg #120 was not medically necessary.

CELEBREX 200 MG, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (nonsteroidal anti-inflammatory drugs) Page(s): 67-69.

Decision rationale: As stated on pages 67-69 of the California MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and there is no evidence of long-term effectiveness for pain or function. Patient has been on this medication since March 2011. The requesting physician notes that this patient has not been using this medication consistently since, as this has not been authorized multiple times in the past, and thus there is no improvement of patient's condition. However, there is no documentation of the patient's recent or current symptoms and examination findings in the progress notes provided for review. There is no assessment of efficacy or response to previous treatment, absence of side effects. Therefore, the request for Celebrex 200mg #30 was not medically necessary.

PRISTIQ 200 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.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain, Selective serotonin and norepinephrine reuptake inhibitors (SNRIs); SNRIs (serotonin noradrenaline reuptake inhibitors) Page(s): 15; 105.

Decision rationale: As noted on pages 15 and 105 of the CA MTUS Chronic Pain Medical Treatment Guidelines, SNRIs are recommended as an option in first-line treatment of neuropathic pain, especially if tricyclics are ineffective, poorly tolerated, or contraindicated. Patient has been on this medication since October 2011. The requesting physician notes that this patient has not been using this medication consistently since, as this has not been authorized multiple times in the past, and thus there is no improvement of patient's condition. However, there is no documentation of the patient's recent or current symptoms and examination findings in the progress notes provided for review. There is no assessment of efficacy or response to previous treatment, absence of side effects. Therefore, the request for Pristiq 200mg #30 was not medically necessary.

TOPAMAX 25 MG, #42: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-21.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that Topiramate is considered for use for neuropathic pain when other anticonvulsants fail. The requesting physician notes that this patient has not been using this medication consistently since, as this has not been authorized multiple times in the past, and thus there is no improvement of patient's condition. However, there is no documentation of the patient's recent or current symptoms and examination findings in the progress notes provided for review. There is no assessment of efficacy or response to previous treatment, absence of side effects. Therefore, the request for Topamax 25mg #42 was not medically necessary.

COMPOUND

FLURBIPROFEN/KETAMINE/HCl/CYCLOBENZAPRINE/GABAPENTIN/LIDOCAINE/PRILOCAINE/LIPODERM CREAM, 90 DAY SUPPLY WITH 1 REFILL: Upheld

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

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

Decision rationale: As noted on page 111-113 of the CA MTUS Chronic Pain Medical Treatment Guidelines, many agents are compounded as monotherapy or in combination for pain control. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen is not currently FDA-approved for topical application. It has an extremely high incidence of photocontact dermatitis. There is little to no research as for the use of flurbiprofen in compounded products. Ketamine is only recommended for treatment of neuropathic pain in refractory cases. Gabapentin is not recommended for use as a topical analgesic. Likewise, cyclobenzaprine has no evidence for use as a topical product.

There is no documentation regarding intolerance to or failure of conventional oral pain medications. There is no discussion concerning the need for variance from the guidelines. Therefore, the request for compound flurbiprofen/ketamine/HCl/cyclobenzaprine/gabapentin/lidocaine/prilocaine/Lipoderm cream 90 day supply with 1 refill was not medically necessary.

TRANSPORTATION TO/FROM MEDICAL VISITS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Transportation (To and From Appointments).

Decision rationale: CA MTUS does not specifically address transportation. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that transportation is recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. In this case, there is no documentation of disabilities preventing the patient from obtaining public or private transportation to and from medical visits. Therefore, the request for transportation to/from medical visits was not medically necessary.

One H-Wave unit between 12/19/2013 and 3/2/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, H-wave stimulation (HWT) Page(s): 117-118.

Decision rationale: According to CA MTUS Chronic Pain Medical Treatment Guidelines pages 117-118, H-wave therapy is not recommended as an isolated intervention, but a one-month home-based trial of H-Wave stimulation may be considered as a noninvasive conservative option for chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration following failure of initially recommended conservative care, including recommended physical therapy, medications, and transcutaneous electrical nerve stimulation (TENS). In this case, there is no documentation of failure of conservative management, or trial of TENS use. Therefore, the request for H-wave unit between 12/19/2013 and 03/2/2014 was not medically necessary.