

Case Number:	CM14-0015278		
Date Assigned:	02/28/2014	Date of Injury:	03/05/2010
Decision Date:	07/23/2014	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	02/06/2014

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 and 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 records presented for review indicate that this 65-year-old individual was injured in March 2010. The mechanism of injury was blunt trauma to the head. The current diagnosis is post lumbar laminectomy syndrome. It is noted that the injured worker continues to have chronic neck and low back pain. The pain level is described as 7/10. The November 2012 progress note indicates incremental improvement. The January 2014 neurologic assessment noted ongoing complaints of pain, and a neurosurgical consultation was pending. The physical examination noted tenderness in the cervical and lumbar musculature. No specific neurologic compromise was noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

OXYCONTIN 40 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, the indication for this medication is for around-the-clock use and not for "as needed" use. Also, the progress

notes provided do not indicate any noted efficacy or utility with the long-term use of this medication. There are multiple pain generators noted; however there has not been any success in dealing with these pain complaints. Therefore, continued use of this medication with significant side effect profile is not indicated based on records presented for review. The request is not medically necessary.

PERCOCET 10/325 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, this medication can be used for chronic back pain starting with the smallest dose and indicated for short term relief. The efficacy of long term use has not been established in the clinical documentation. Furthermore, when noting that multiple other interventions have not been successful, there is insufficient clinical data demonstrating the efficacy or utility of this preparation. As such, the request is not medically necessary.

CYMBALTA 60 MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 42.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Cymbalta is a selective serotonin and norepinephrine reuptake inhibitor. It is recommended as a first-line option for diabetic neuropathy; though increasing off label use of this medication exists for various pain syndromes, such as anxiety, depression, diabetic neuropathy, and fibromyalgia. When noting that the record does not reflect that the injured worker has any of these conditions, there would be no clinical indication to support the use of Cymbalta. Furthermore, it does not appear that there is any efficacy or utility of the chronic, indefinite use of this preparation. As such, the request is not medically necessary.

TOPAMAX 100 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, the use of this medication is a second line intervention after other anticonvulsant medications have been proven unsuccessful. Based on the ongoing complaints of pain, still noted in the 7/10 range, it does not appear that this medication has had any success in terms of dealing with the pain generators. As such, the request is not medically necessary.

ZANAFLEX 4 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity. It is unlabeled for use in low back pain. Muscle relaxants are only indicated as second line options for short-term treatment. It appears that this medication is being used on a chronic basis which is against the guideline recommendations. As such, the request is not medically necessary.

1-12 PANEL URINE DRUG SCREEN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going management (e.), criteria for use CRITERIA FOR USE OF OPIOIDS Page(s): 78.

Decision rationale: According to the Chronic Pain Medical Guidelines, such testing is indicated if there was a suggestion of illegal drug use, inappropriate prescription medication use, or other abuses of the process. Based on the clinical data presented, the medications prescribed to be used appropriately there is no evidence of addiction or inappropriate utilization or diversion. Therefore, when noting the criterion outlined in the MTUS and noting no evidence of addiction or abuse, there is insufficient clinical data presented to support this request. Recommend non certification.

1 SERIES OF 8 LOW BACK AND CERVICAL TRIGGER POINT INJECTIONS UNDER ULTRASOUND GUIDANCE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, such injections are only indicated when there is a myofascial pain syndrome. There is a limited lasting value associated with such injections. As such, these injections are not recommended for radicular pain. This is an individual who has a post surgery syndrome in both the cervical spine and lumbar spine, has multiple pain generators, and has poor control of the pain complaints. As such, when noting the pain generators and the parameters listed in the MTUS, the request is not medically necessary.