

Case Number:	CM14-0123490		
Date Assigned:	08/08/2014	Date of Injury:	01/17/2008
Decision Date:	10/02/2014	UR Denial Date:	07/31/2014
Priority:	Standard	Application Received:	08/05/2014

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 Internal 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 injured worker is a 67 year old female injured on 01/17/08 as a result of continuous trauma resulting in bilateral wrist, hand, knee and low back pain. Diagnoses included bilateral upper extremities overuse, bilateral carpal tunnel syndrome, status post bilateral carpal tunnel release in 2010 with residual, basilar joint arthritis bilaterally, lumbar spine spondylolisthesis L4-5 and L5-S1, status post two lumbar fusions, right knee arthroscopy and right total knee replacement, history of prior left knee surgery, and left knee degenerative joint disease. Agreed Medical Exam on 08/05/13 indicated the injured worker presented complaining of low back pain radiating to bilateral lower extremities with associated numbness, bilateral knee pain with numbness in right knee, and bilateral wrist/hand pain radiating to the fingers with associated numbness. There was no recent clinical documentation submitted for review. The request for oxycodone/acetaminophen 5/325mg, cyclobenzaprine 10mg, and duloxetine 30mg was non-certified on 07/31/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone/acetaminophen 5/325mg.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Chronic Pain Medical Treatment Guidelines: Therapeutic Trail of Op.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
CRITERIA FOR USE OF OPIOIDS Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There were no clinical records submitted for review limiting the ability to substantiate functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Additionally, the request failed to provide frequency, amount, and number of refills to be provided. As such, Oxycodone/acetaminophen 5/325mg cannot be recommended as medically necessary.

Cyclobenzaprine 10mg.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Chronic Pain Medical Treatment Guidelines: Muscle Relaxants (for P.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20,
CYCLOBENZAPRINE Page(s): 41.

Decision rationale: As noted on page 41 of the Chronic Pain Medical Treatment Guidelines, cyclobenzaprine is recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. There were no clinical records submitted for review limiting the ability to substantiate the medical necessity of the requested medication. Additionally, the request failed to provide frequency, amount, and number of refills to be provided. As such, the medical necessity of cyclobenzaprine 10mg cannot be established at this time. Therefore the request is not medically necessary.

Duloxetine 30mg.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Chronic Pain Medical Treatment Guidelines: Antidepressants for Chro.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20,
Duloxetine (Cymbalta) Page(s): 44.

Decision rationale: As noted on page 44 of the Chronic Pain Medical Treatment Guidelines, Cymbalta is recommended as an option in first-line treatment of neuropathic pain. It has Food and Drug Administration approval for treatment of depression, generalized anxiety disorder, and for the treatment of pain related to diabetic neuropathy, with effect found to be significant by the end of week 1. There were no clinical records submitted for review limiting the ability to substantiate the medical necessity of the requested medication. Additionally, the request failed to provide frequency, amount, and number of refills to be provided. As such, the request for Duloxetine 30mg cannot be recommended as medically necessary.

