

Case Number:	CM14-0152255		
Date Assigned:	10/23/2014	Date of Injury:	03/31/2007
Decision Date:	12/02/2014	UR Denial Date:	09/11/2014
Priority:	Standard	Application Received:	09/18/2014

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 Orthopedic Surgery and is licensed to practice in New York. 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:

This case involves a patient who sustained an injury on March 31, 2007 and has chronic neck pain. Her treatment to date has included cervical fusion at C5-6 performed in February 2008 and a revision anterior cervical discectomy and fusion (ACDF) in November 2011. She continues to have chronic neck pain. Electrodiagnostic studies from 2012 show bilateral median nerve neuropathy at the wrists with mild carpal tunnel and right C7 radiculopathy and left C6-7 radiculopathy. The patient is admitted to daily alcohol use and takes multiple medications for pain. She had a history of gastric bypass surgery. At issue is whether multiple medications are medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta 60mg, 1 by mouth two times per day, #60 with 6 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine. Decision based on Non-MTUS Citation FDA: Cymbalta

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Cymbalta is approved to treat major depression in adults and to match pain associated with diabetic peripheral neuropathy. The medical records do not indicate that this

patient has diabetic peripheral neuropathy or major depression. Therefore, based on the guidelines and the medical records, this request is not medically necessary.

Lidoderm patch 5%, 1 patch 12 hours on and 12 hours off, with 6 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Guidelines indicate that this drug was used for neuropathic pain and is also useful or stable for diabetic neuropathy. This drug is recommended only for peripheral pain after has been evidence of a trial first-line therapy with Tri-Cyclic antidepressants or gabapentin. The medical records do not indicate that this patient has successfully completed first-line treatment. Therefore, this request is not medically necessary.

Topamax 100mg, 1 tablet by mouth two times per day #60 with 6 refills (prescribed 9/4/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDS). Decision based on Non-MTUS Citation FDA Topamax

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Topamax is FDA approved to treat seizures and adults with epilepsy as well as migraine prophylaxis. The FDA indications for this drug are not present in this case; therefore, this request is not medically necessary.

Trazadone 150mg, 1 tablet by mouth at bedtime #30 with 6 refills (prescribed 9/4/14): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Apothecan Inc. (2004) Desyrel (Trazadone)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Per guidelines, this medicine is an oral antidepressant drug indicated for the treatment of depression. However, this patient has not been diagnosed with major depression. Based on guidelines and medical records provided, this request is not medically necessary.

Fentanyl 50mcg/hr, 1 patch every 48 hours, #15 with no refills (prescribed 9/4/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates (Criteria for use). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Opioids, Dosing

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Guidelines do not recommend narcotic usage for chronic pain. In addition, the medical records do not indicate that the patient had functional improvement previous narcotic use. Therefore, based on the guidelines and the medical records provided, this request is not medically necessary. ary.

Percocet 10/325mg, 2 by mouth four times per day as needed for pain #240 with no refills (prescribed 9/4/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Criteria for use). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Opioids (When to Discontinue/Dosing)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Guidelines do not recommend narcotic usage for chronic pain. In addition, the medical records do not indicate that the patient had functional improvement previous narcotic use. Therefore, based on the guidelines and medical records provided, this request is not medically necessary.

Ondansetron 8 mg, 1 by mouth three times per day, #90 with 5 refills (prescribed 9/4/14): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Antiemetics (for Opioid Nausea), Ondansetron (Zofran)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: This medication is not recommended for nausea and vomiting secondary to chronic opioid use. This patient has been taking long-term narcotics and this drug is not recommended for long-term uses. In addition, the medical records do not document that the patient has used other first-line antiemetic. Therefore, based on the guidelines and medical records provided, this request is not medically necessary.

Robaxin 750mg, 2 tablets by mouth four times per day for spasms, #240 with 6 refills (prescribed 9/4/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Methocabamol/Muscle Relaxants (for Pain).

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Muscle relaxants are not recommended for use and chronic low back pain. Studies show that they indicate no benefit beyond non-steroidal anti-inflammatory drugs

(NSAIDs) use and chronic low back pain cases. This patient has chronic low back pain resulting in the criteria for Robaxin not being met. Therefore, this request is not medically necessary.