

Case Number:	CM14-0156975		
Date Assigned:	10/02/2014	Date of Injury:	01/27/2003
Decision Date:	11/17/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/25/2014

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 Louisiana. 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 48 year old female who was injured on 01/27/2003 when she slipped and fell. Prior treatment history has included acupuncture therapy but there is no documentation of its outcome or benefit; physical therapy, massage therapy, LESI and injection. Progress report dated 07/01/2014 documented the patient to have complaints of low back pain with radiation to the right buttock, thigh and hip; neck pain, right greater than left; bilateral shoulder pain; tailbone pain; mid back pain; dysphagia; and weakness of the right upper extremity and right lower extremity. She rated her pain without medications a 10/10 and with medications a 7/10. With the medications, she reportedly can do a little more sitting, standing, and walking with medications and is able to remain independent with her activities of daily living. On exam, the cervical spine has palpable spasms of the paraspinal muscles bilaterally. Range of motion is limited with flexion at 80%; extension at 50%; right lateral flexion at 40% and left lateral flexion at 40%. The lumbar spine revealed moderate paralumbar muscle spasm, right greater than left. AROM revealed the patient is able to flex 40% of normal; extension is 10%; and lateral flexion is 30%. Straight leg raise is positive bilaterally at 60% in sitting positive producing posterior thigh and calf pain bilaterally. Lasegue's Test is positive bilaterally in seated position. The patient is diagnosed with lumbar radiculopathy, right cervical radiculopathy, coccygeal fracture, thoracic strain and bilateral shoulder strain. The report mentions the pain rating with medications but does not note what those medications are. Prior utilization review dated 09/09/2014 states the request for Nucynta 50mg tablet 1 QID PRN for pain #100 is denied as it is recommended as a second line therapy and there is no documentation of failed first line therapy; Senokot tablet 1-2 QPM for constipation #60; Lidoderm patch 5% 1-2 Q24H for pain on lower back and neck area #60; and Oxycontin 10mg tablet 1-2 BID #90 is denied as the medical

necessity of this request cannot be validated as there is a lack of documented evidence to support these requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nucynta 50mg tablet #100: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, TWC, Online Edition, Chapter Pain, Tapentadol

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-96.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Nucynta is an opioid recommended as the standard of care for treatment of moderate to severe pain for short-term use. Guidelines do not recommend continued use unless there is documented evidence of objective pain and functional improvement. In this case, there is no documentation of improvement in pain as the pain was rated the same with and without medication. Nucynta is not recommended for long-term use without documented evidence of improvement therefore, this is not medically necessity.

Senokot tablet #60: 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 Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/mtm/senokot-s.html>

Decision rationale: According to other Medical Treatment Guidelines, Senokot is recommended for relief of constipation. Constipation is the most common side effect of taking opioids regularly for pain. In this case, there is no supporting documentation to indicate the necessity as there is no evidence of relief and the requested opioids have been deemed not medically necessary. Therefore, the request is not medically necessary.

Lidoderm patch 5% #60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/lidoderm.html>

Decision rationale: Based on the Chronic Pain Medical Treatment Guidelines, Lidoderm is recommended for a trial if there is evidence of localized pain that is consistent with neuropathic etiology and should be used for a short-term period (no more than four weeks.) Continued outcomes should be intermittently measured and if improvement does not continue, Lidoderm should be discontinued. The supporting documentation indicated the use of Lidoderm for over four weeks without any sustainable improvement and the ongoing use of this medication is not recommended by the guidelines, therefore this is not medically necessary.

Oxycontin 10mg tablet #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-96.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, OxyContin is an opioid recommended as the standard of care for treatment of moderate to severe pain for short-term use. Guidelines do not recommend continued use unless there is documented evidence of objective pain and functional improvement. In this case, there is no documentation of improvement in pain as the pain was rated the same with and without medication. OxyContin is not recommended for long-term use without documented evidence of improvement therefore, this is not medically necessary.