

Case Number:	CM14-0168056		
Date Assigned:	10/15/2014	Date of Injury:	07/19/2010
Decision Date:	12/08/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	10/13/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Ohio and Texas. 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 62-year-old female who reported an injury on 07/19/2010. The mechanism of injury was not submitted for review. The injured worker had diagnoses of chronic low back pain, chronic lumbar radiculopathy worse on the left side, status post lumbar decompression surgery, status post spinal cord stimulator placement, right elbow epicondylitis, complex chronic pain syndrome associated with anxiety and limited functional status. Past medical treatment consists of surgery, physical therapy, spinal cord stimulator and medication therapy. Medications consisted of Duragesic patch, Norco 10/325, Lyrica and Cymbalta. No drug screen or urinalysis was submitted for review. On 09/10/2014, the injured worker complained of low back pain and bilateral leg pain. It was noted on physical examination that the pain rate was 5/10 to 8/10. Physical examination of the lumbar spine revealed limited range of motion in all directions. There was diminished sensation in the L5 dermatome on the left. Strength was 4/5 in the left knee extensors. There was no visible muscle atrophy. Right elbow range of motion was full. It was also noted that there was tenderness over the lateral epicondyle. Medical treatment plan was for the injured worker to continue with medication therapy. The provider felt that the injured worker was doing very well with medications. The Request for Authorization form was submitted on 07/18/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duragesic Patch 25mcg an hour every three days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl) ,ongoing management,opioid dosing Page(s): 44,78,86.

Decision rationale: The request for Duragesic patch is not medically necessary. The submitted documentation did not indicate the efficacy of the medication, nor did it indicate that the patches were helping with any functional deficits the injured worker might have had. MTUS Guidelines recommend documentation of objective improvement in function, objective decrease in pain and evidence that the patient is being monitored for aberrant drug behavior and side effects. There were no urinalysis or drug screens submitted for review showing that the injured worker was compliant with MTUS recommended guidelines. Additionally, there were no assessments submitted for review showing objective decrease in pain, nor was there any indication what pain levels were before, during and after medication administration. Furthermore, the request as submitted did not indicate a duration of the medication. Given the above, the injured worker is not within the recommended guideline criteria. As such, the request is not medically necessary.

Norco 10/325mg three times a day as needed for incidental pain: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Short acting Opioids; Norco.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Norco,Ongoing Management Page(s): 75,78.

Decision rationale: The request for Norco 10/325 is not medically necessary. The submitted documentation did not indicate the efficacy of the medication, nor did it indicate that the medication was helping with any functional deficits the injured worker might have had. Additionally, there were no assessments submitted for review showing objective decrease in pain nor was there any indication what pain levels were before, during and after medication administration. The request as submitted also did not indicate a duration of the medication. Furthermore, there were no drug screens or UA's submitted for review showing that the injured worker was compliant with prescriptions. Given the above, the injured worker is not within MTUS recommended guideline criteria. As such, the request is not medically necessary.

Lyrica: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin(Lyrica) ; anti-epilepsy drugs (AEDs) general guidelines.

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

Decision rationale: The request for Lyrica is not medically necessary. According to MTUS Lyrica is an anticonvulsant that has been documented to be effective in the treatment of diabetic neuropathy and postherpetic neuralgia. The submitted documentation lacked the efficacy of the medication, nor did it indicate that the Lyrica was helping with any functional deficits the injured worker had. Furthermore, there was no indication in the submitted report that the injured worker had a diagnosis congruent with the above guidelines. The physical examination that was submitted for review was very minimal and did not include any pertinent functional deficits of the injured worker. Additionally, the request as submitted did not indicate a dosage, frequency or duration of the medication. Given the above, the injured worker is not within the MTUS recommended guideline criteria. As such, the request is not medically necessary.

Cymbalta: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 43.

Decision rationale: The request for Cymbalta is not medically necessary. According to the California MTUS recommended guidelines, Cymbalta is an option in first line treatment for neuropathic pain. Assessments of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in the use of other analgesic medication, sleep quality and duration and psychological assessment. The submitted documentation did not indicate the efficacy of the medication nor did it indicate that the Cymbalta was helping with any functional deficits. Additionally, there was no evidence of an objective assessment of the injured worker's pain level. Furthermore, there was lack of documented evidence showing that the injured worker had a diagnosis congruent with the above guidelines. There were no psychological assessments submitted for review. Furthermore, the request as submitted did not indicate a dosage, frequency or duration of the medication. Given the above, the injured worker is not within recommended guideline criteria. As such, the request is not medically necessary.

Tizanidine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines; Tizanidine (Zanaflex, generic avail).

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

Decision rationale: The request for tizanidine is not medically necessary. According to the California MTUS, they recommend tizanidine as a non-sedating muscle relaxant with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. These types of medication are not recommended to be used for longer than 2 to 3 weeks. The submitted documentation did not indicate the efficacy of the medication, nor did it

indicate that the medication was helping with any functional deficits the injured worker had. Additionally, the submitted documentation indicated that the injured worker had been taking tizanidine since at least 07/18/2014, exceeding the recommended guidelines for short term use. Furthermore, there was no rationale submitted for review to warrant the continuation of the medication. The request, as submitted also did not indicate a dosage, frequency or duration. Given the above, the injured worker is not within the recommended guideline criteria. As such, the request is not medically necessary.