MAXIMUS Federal Services

Case Number:	CM14-0035886		
Date Assigned:	07/30/2014	Date of Injury:	08/23/2005
Decision Date:	09/09/2014	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	03/24/2014

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 45 year old individual was reportedly injured on August 23, 2005. The mechanism of injury was noted as repetitive overuse secondary to typing. The most recent progress note, dated January 14, 2014, indicated that there were ongoing complaints of neck and mid back pains. The physical examination was not available for review, rather a narrative as to why the multiple medications were required. Diagnostic imaging studies were not presented for review. Previous treatment included cervical and thoracic fusion surgery, pseudoarthrosis treatment, revision surgery, injection therapies, acupuncture, transcutaneous electrical nerve stimulation (TENS) and multiple medications. A request was made for multiple medications and was not certified in the preauthorization process on March 12, 2014. A partial approval of the medication Oxycodone, Wellbutrin, OxyContin, Tizanidine and Impramine were noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 30 mg #120/30 days for 6 months: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74,78,93 of 127.

Decision rationale: The records, presented for review, reflect that the injured worker was stable on Lortab 7.5 milligrams and OxyContin 40 milligrams. Previous reviewers endorsed a modified protocol and not a six month regimen. As outlined in the Medical Treatment Utilization Schedule (MTUS), these particularly short acting opioids are for short term management of moderate to severe breakthrough pain. Therefore, careful monitoring is required. As such, a six month protocol is not medically indicated.

Oxycontin CR 80 mg #90/30days for 6 months: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74,78,93 of 127.

Decision rationale: As noted in the progress notes, the pain was well controlled on OxyContin 40 milligrams per day. The request was for twice the strength. Furthermore, as noted in the Medical Treatment Utilization Schedule (MTUS), when injured workers are taking more than one opioid, careful control of the medication is necessary, and careful management of the lowest possible dose is required. Furthermore, careful monitoring is required, and a six month trial is not medically necessary.

Wellbutrin XL 150mg #90/30days for 6 months: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16, 27 & 125 of 127.

Decision rationale: This medication is noted as a second generation, nontricyclic antidepressant, which has been shown to have some efficacy in relieving neuropathic pain. However, as noted in the progress notes, the pain levels were controlled; however, not ameliorated with multiple narcotic medications. Therefore, the efficacy of this medication has not been objectified. Accordingly, the medical necessity of continued intervention use of this medication was not presented.

Abilify 5mg #30/30days for 6 months: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Atypical Antipsychotics.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG), Mental Illness & Stress.

Decision rationale: It is noted that the Medical Treatment Utilization Schedule (MTUS) and American College of Occupational and Environmental Medicine (ACOEM) guidelines do not address antipsychotic medications. As noted in the Official Disability Guidelines (ODG), this is not recommended for first line treatment. The records, presented for review, did not objectify or substantiate that this medication has demonstrated any efficacy or utility to treat the ongoing chronic pain situation. As such, without such data, this is not determined to be medically necessary.

Tizanidine 4 mg #120/30 days for 6 months: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66 of 127.

Decision rationale: Tizanidine is a centrally acting medication approved for the management of spasticity. This was not identified in the progress note presented for review. There were noted muscle spasms, which are far different. Furthermore, based on the progress notes presented, there was no notation of any efficacy or utility in terms of addressing these findings with this medication. As such, the medical necessity for additional six months of this preparation has not been presented.

Imipramine 50mg #240/30days for 6 months: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter, updated July 2014.

Decision rationale: This medication is not addressed in the Medical Treatment Utilization Schedule (MTUS) or American College of Occupational and Environmental Medicine (ACOEM) guidelines. The parameters noted in the ODG are employed. There is a recommendation for the use of this medication in the treatment of chronic pain. There is some indication for uses of this medication to address for some neuropathic lesion; however, there was no objectification presented of any efficacy or utility with the ongoing use of this medication. As such, this is not considered to be medically necessary.