

Case Number:	CM14-0037040		
Date Assigned:	06/25/2014	Date of Injury:	10/03/2008
Decision Date:	09/05/2014	UR Denial Date:	03/18/2014
Priority:	Standard	Application Received:	03/27/2014

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 injured worker is a 65-year-old male who was reportedly injured on October 3, 2008. The mechanism of injury was noted as a trip and fall type event. The injury included the low back, right elbow, left shoulder and thoracic regions of the spine. The most recent progress note, dated March 17 2014, indicated that there were ongoing complaints of low back, right ankle and left shoulder pains. The physical examination demonstrated an alert, oriented, borderline hypertensive (134/83) individual who demonstrated some truncal obesity. There was tenderness to palpation in the cervical lumbar regions of the spine. No particular neurological findings were reported. Diagnostic imaging studies were not reviewed. Previous treatment included more than 20 separate medications, chronic pain management protocols and left shoulder surgery. A request had been made for multiple medications and was not certified in the pre-authorization process on March 18, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin ER 10 mg qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 97.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 74, 78, 93.

Decision rationale: MTUS guidelines support long-acting opiates in the management of chronic pain, when continuous around-the-clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The medical records presented did not demonstrate any of these criteria. The pain levels were documented to be 9/10. The injured worker suffered from chronic pain; however, there was no documentation of improvement in the pain level or function with the current treatment regimen. In the absence of subjective or objective clinical data, this request is not considered medically necessary.

Oxycodone 10 mg qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 74, 78, 93.

Decision rationale: California Medical Treatment Utilization Schedule supports short-acting opiates for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there was no clinical documentation of improvement in the pain or function with the current regimen. The pain levels remained at 9/10. As such, this request is not considered medically necessary, based on the clinical information presented for review.

Celexa 20 mg qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 16.

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 10, 2014.

Decision rationale: According to Official Disability Guidelines this medication is noted to be an N drug and is a SSRI (selective serotonin reuptake inhibitor). These medications are not recommended for the treatment of chronic pain. Therefore, when noting the marginal progress presented for review and by the parameters outlined in the Official Disability Guidelines, this is not medically necessary.

Gralise 600 mg qty 450: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19, 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 16-20, 49.

Decision rationale: This medication is considered to be a first-line treatment for neuropathic pain and ongoing complaints of shoulder pain and low back pain. There was no objective documentation of a neuropathic lesion being the pain generator. Furthermore, there was no objectification of any efficacy or utility with this medication. As such, the medical necessity for this preparation is not necessary based on the progress notes presented for review.

Skelaxin 800 mg qty 480: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009): Anti-Spasticity/Anti-spasmodic drugs Page(s): 66.

Decision rationale: When considering the date of injury, the mechanism of injury, the current complaints of shoulder and back pain and by the very minimal physical examination offered, there was insufficient clinical evidence presented to suggest the need for an indefinite use for this medication. As noted in the California MTUS, muscle relaxant medications are only indicated for second line options in the short term. There was no clinical indication for chronic or indefinite use and this medication is recommended for short-term intervention only. As such, the medical necessity for this preparation has not been established.

Medical myofascial release qty 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 98-99.

Decision rationale: The use of physical therapy or myofascial release is based upon certain physical examination findings when considering this injury occurred a number of years ago. Therefore, while noting the California MTUS of passive therapy is not supported for chronic pain, active interventions are. There was no documentation of what home protocol was being employed, or what physical examination findings were to be addressed with such intervention. Therefore, based on the lack of clinical information, there is insufficient data to support the medical necessity of this request.