

Case Number:	CM14-0058492		
Date Assigned:	08/08/2014	Date of Injury:	02/25/2008
Decision Date:	09/11/2014	UR Denial Date:	04/16/2014
Priority:	Standard	Application Received:	04/29/2014

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 40 year-old male who was reportedly injured on February 25, 2008. The mechanism of injury is not listed in these records reviewed). The most recent progress note dated March 3, 2014, indicates that there are ongoing complaints of low back pain. The physical examination was not presented. Diagnostic imaging studies objectified ordinary disease of life degenerative changes at multiple levels in the cervical and lumbar spine. Previous treatment includes psychiatric evaluations, multiple enhanced imaging studies, multiple medications, and pain management intervention. A request was made for multiple medications and was not certified in the pre-authorization process on April 16, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Nortriptyline 25 mg, QTY: 90 capsules with 3 refills, as prescribed on 3-31-14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 43, 105 of 127.

Decision rationale: There is quality evidence evaluating anti-depressants for the treatment of chronic pain. The inhibition of norepinephrine re uptake appears to be the key mechanism of analgesia. The prototypical medications to produce these effects are the tricyclic antidepressants. However, when reviewing the progress of presented for review there is no objectification of any efficacy or utility with the continued use of this preparation. There is no noted decrease in symptomology, increasing functionality or return to work. As such, based on the clinical information presented for review, the request is not medically necessary.

Retrospective request for Norco 10/325 mg, QTY: 180 tablets, as prescribed on 3-31-14:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Hydrocodone/Acetaminophen. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation (TWC), 2012, Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 74-78, 88, 91 of 127.

Decision rationale: As outlined in the California Medical Treatment Utilization Schedule, this medication is a short acting opioid indicated for management of moderate to severe breakthrough pain. However, the continued use of this medication must be supported with documentation of functional improvement, decrease symptomology or other objective parameters noting the efficacy of this preparation. Therefore, when noting that there is no objectification of any efficacy or utility, or overall improvement in symptomology, the request is not medically necessary.

Retrospective request for Tizanidine 4 mg, QTY: 60 capsules with 3 refills, as prescribed on 3-31-14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS; (Effective July 18, 2009) Antispasticity/Antispasmodic Drugs Page(s): 66 of 127.

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha 2-adrenergic agonist that is Food and Drug Administration approved for management of spasticity. It is unlabeled for use in low back pain. Muscle relaxants are only indicated as 2nd line options for short-term treatment. It appears that this medication is being used on a chronic basis which is not supported by California Medical Treatment Utilization Schedule treatment guidelines. Therefore, when noting that there is no objectification of any efficacy or utility or overall improvement in symptomology, the request for this medication is not medically necessary.

Retrospective request for Gabapentin 600 mg, QTY: 270 tablets with 3 refills, as prescribed on 3-31-14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 16-20, 49 of 127.

Decision rationale: As outlined in the California Medical Treatment Utilization Schedule, this medication is considered a first-line treatment for neuropathic pain. However, there is no evidence of a specific neuropathic lesion or radicular findings. Furthermore, there is no data to suggest that this medication has demonstrated any efficacy or utility industry of these pain complaints. There is no noted increase in functionality, decrease in symptomology or any other parameter denoting the medication has having its intended effect. Therefore, the request is not medically necessary.

Retrospective request for Cymbalta 60 mg, QTY: 30 capsules with 4 refills, as prescribed on 3-31-14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 16-20, 49 of 127.

Decision rationale: As outlined in the California Medical Treatment Utilization Schedule, this medication is considered a first-line treatment for neuropathic pain. However, there is no evidence of a specific neuropathic lesion or radicular findings. Furthermore, there is no data to suggest that this medication has demonstrated any efficacy or utility industry of these pain complaints. There is no noted increase in functionality, decrease in symptomology or any other parameter denoting the medication as having its intended effect. Therefore, the request is not medically necessary.

Retrospective request for Colace 250 mg, QTY: 60 capsules with 3 refills, as prescribed on 3-31-14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Roberts Pharmaceutical (2004) Colace Oral.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26, MTUS (Effective July 18, 2009) Page(s): 77 OF 127.

Decision rationale: There is no clinical indication for this medication for this claimant. There is documentation of narcotic usage; however, there is no documentation of constipation side effects. Colace is available as a generic formulation and it is also available as an over the counter product without a prescription. Based on the records reviewed, the medical necessity cannot be established. Therefor the request is not medically necessary.

Retrospective request for Avinza 45 mg, QTY: 60 capsules, as prescribed on 3-31-14:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Morphine Sulfate. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation (TWC), 2012, Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 74, 75, 78, 93 of 127.

Decision rationale: California Medical Treatment Utilization Schedule 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 injured worker suffers from chronic pain; however, there is no documentation of improvement in their pain level or function with the current treatment regimen. In the absence of subjective or objective clinical data, this request is not medically necessary.