

Case Number:	CM14-0067642		
Date Assigned:	07/11/2014	Date of Injury:	10/30/1996
Decision Date:	08/13/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/12/2014

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 Interventional Spine and is licensed to practice in California. 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 46-year-old female with date of injury of 10/30/1996. The listed diagnoses per [REDACTED] dated 02/19/2014 are: 1. Cervical pain. 2. Degenerative disk disease, cervical spine. 3. Cervical stenosis. 4. Acquired spondylolisthesis. According to this report, the patient complains of neck pain. She complains of generalized discomfort all over her body. The patient reports burning sensation in her neck and arms with decreased range of motion to her neck. She states the pain is alleviated by the use of medication, ice, and Voltaren cream. The physical examination shows the patient stands without any obvious spinal deformity. There is decreased range of motion in the neck and lumbar spine both of which are possibly limited due to her body habitus. There is no tenderness to palpation of the cervical spine, thoracic spine, and lumbar spine. Motor exam shows 4+/5 in all four extremities. Sensation is intact to light touch in all her major dermatomal areas of the upper extremities and lower extremities. Deep tendon reflexes are 2+ bilaterally. She has a slow gait with slight wobble but is steady. The utilization review denied the request on 05/06/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Refill Percocet 10/325mg, QTY: 210 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Opioid Use and Tapering of medication. Decision based on Non-MTUS Citation American Pain Society (APS) and American Academy of Pain Medicine (AAPM) Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

Decision rationale: This patient presents with neck pain. The treater is requesting Percocet 10/325 mg #210. For chronic opiate use, the MTUS Guidelines require specific documentations regarding pain and function. Page 78 of MTUS Guidelines requires pain assessment that requires current pain; the least reported pain over the periods since last assessment; average pain; intensity of pain after taking the opioids; how long it takes for pain relief; and how long pain relief last. Furthermore, the 4As for ongoing monitoring are required which includes: analgesia, ADLs, adverse side effects, and aberrant drug seeking behavior. The records show that the patient has been taking Percocet since 2010. The treater documents that the patient's pain is alleviated with medications but does not provide before/after analgesia, no specifics regarding ADL's to denote significant improvement, no mention of quality of life changes and no discussion regarding pain assessments, as required by MTUS. There are no discussions regarding adverse side effects and urine.drug screening to detect any adverse drug seeking behavior. The request for Percocet 10/325mg, QTY 120 with 1 refill is not medically necessary.

Refill Flexeril 10mg, QTY: 120 with 4 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available) Page(s): 64.

Decision rationale: This patient presents with neck pain. The treater is requesting a refill for Flexeril 10 mg #120. The MTUS Guidelines page 64 on cyclobenzaprine states that it is recommended as a short course of therapy with limited mixed evidence not allowing for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and essential nervous system depressant with similar effects to tricyclic antidepressants (e.g. amitriptyline). In addition, this medication is not recommended to be used for longer than 2 to 3 weeks. The treater documents medication efficacy on 05/01/2014 stating, Flexeril helps, but not long acting enough. It appears that the patient has used Flexeril prior to the most recent report; however, the documents are not clear as to when the patient started taking it. In this case, Flexeril is not recommended for long term use. Furthermore, the quantity requested exceeds MTUS recommended 2 to 3-week treatment time frame. The request for Flexeril 10mg, QTY 120, with 4 refills is not medically necessary.

Voltaren Gel 1% with 4 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: This patient presents with neck pain. The treater is requesting Voltaren gel 1% with 4 refills. The MTUS Guidelines page 111 on topical analgesics states that it is primarily recommended for neuropathic pain when trial of antidepressants and anticonvulsants have failed. Furthermore, Voltaren gel 1% (diclofenac) is indicated for relief of osteoarthritis, pain in joints that lend themselves to topical treatment such as ankle, elbow, foot, hand, knee, and wrist. It is not recommended for the treatment of the spine, hip, or shoulder. The records show that the patient was prescribed Voltaren gel on 01/02/2014. However, the patient does have a diagnosis of osteoarthritis. Furthermore, it appears that the patient is using Voltaren for the neck and low back, which this medication is not indicated for. The request for Voltaren Gel 1 % with 4 refills is not medically necessary.