

Case Number:	CM14-0076623		
Date Assigned:	08/06/2014	Date of Injury:	06/26/1997
Decision Date:	09/25/2014	UR Denial Date:	05/08/2014
Priority:	Standard	Application Received:	05/27/2014

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 records, presented for review, indicate that this 55-year-old individual was reportedly injured on June 26, 1997. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated August 19, 2014, indicated that there were ongoing complaints of multifocal body pain. The physical examination demonstrated a 5'8", 210 pound individual who was slightly tachycardic (103 bpm). The injured employee was noted to be in no acute distress. The motor and sensory examination was intact. A slight decrease in upper extremity range of motion was reported. Diagnostic imaging studies objectified but were not reported. Previous treatment included multiple narcotic medications. A request had been made for genetic drug testing and medications and was not certified in the pre-authorization process on May 8, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Genetic Drug Metabolism Lab Test: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cytokine DNA testing for pain Page(s): 42 of 127.

Decision rationale: As outlined in the MTUS, this procedure is not recommended. There is no clinical support for the use of cytokine DNA testing in the treatment of chronic pain. While noting that research is rapidly evolving, there is little scientific data to support this request. Therefore, based on the clinical information reviewed and by the parameters noted in the MTUS, this is not medically necessary.

Genetic Testing Narcotic Risk: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cytokine DNA testing for pain Page(s): 42 of 127.

Decision rationale: As outlined in the MTUS, this procedure is not recommended. There is no clinical support for the use of cytokine DNA testing in the treatment of chronic pain. While noting that research is rapidly evolving, there is little scientific data to support this request. Therefore, based on the clinical information reviewed and by the parameters noted in the MTUS, this is not medically necessary.

Percocet 10/325mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-78, 88, 91 of 127.

Decision rationale: This medication is a short acting opiate indicated for the management of moderate to severe breakthrough pain. However, this medication is being prescribed on a routine basis, and there is no objectification of improvement in pain complaints or in functionality. It is noted that there is subjective improvement by 50%; however, the medication usage has not decreased. Furthermore, it is not clear what this individual can do from a functional perspective based on the progress notes presented. There is no objective clinical evidence suggesting the pain has improved and that functionality of the injured employee has increased. Therefore, while noting that urine drug screening, and opioid contract is to being followed, there does not appear to be any significant improvement. As such, the medical necessity has not been established.

Ambien 10mg #30, 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Pain (Chronic).

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, Zolpidem updated August 2014.

Decision rationale: As outlined in the ODG (MTUS and ACOEM do not address), this medication is indicated for the short-term treatment of insomnia. It is noted that there is a chronic insomnia situation; however, what is not noted is the efficacy of this medication relative to the insomnia complaints. Furthermore, there is no data to suggest an evaluation other than the subjective complaints were noted. Therefore, there is insufficient clinical evidence presented to support the medical necessity of this medication on an indefinite or chronic basis.

Baclofen 10mg #30, 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 63, 64 of 127.

Decision rationale: The mechanism of action of this medication is to block presynaptic receptors. However, this is indicated for those issues of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. Neither malady is noted in this case. Furthermore, the progress notes did not demonstrate any efficacy or utility in terms of the decreasing spastic situation or muscle spasm on physical examination. As such, there is insufficient clinical information presented to support this request.

Ibuprofen 600mg #30, 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22 of 127.

Decision rationale: Ibuprofen is a nonselective, non-steroidal anti-inflammatory medication that has some indication for chronic low back pain. However, when noting the date of injury, the injury sustained, the current diagnosis and the complete lack of any improvement in the overall symptomatology, there is no objective evidence presented to suggest that this medication is having any efficacy whatsoever. Therefore, while noting that there is an indication, there needs to be objectified data to support this continued use. The medical necessity has not been established in the progress notes reviewed.

Neurontin 800mg #120, 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-20, 49 of 127.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines consider gabapentin to be a first-line treatment for neuropathic pain. Based on the clinical documentation provided, there is no evidence that the injured employee has any neuropathic pain nor are any radicular symptoms noted on physical examination. As such, this request for Neurontin is not medically necessary.