

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0085140 | | |
| Date Assigned: | 07/23/2014 | Date of Injury: | 11/29/1996 |
| Decision Date: | 08/27/2014 | UR Denial Date: | 05/19/2014 |
| Priority: | Standard | Application Received: | 06/06/2014 |

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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 claimant is a 56 year old presenting with chronic pain following a work related injury on 11/29/1996. On 10/29/2013 the claimant reported return of pain in the low back that radiated to the right lower extremity. The claimant's had an injection and reported benefit. The claimant's medications include Fentanyl 50mcg/hr. patch, Mobic 7.5mg, Percocet 10/325mg, Skelaxin 800mg, and Zoloft 50 Mg Tablet. The physical on that day was not documented except for the vital signs. The claimant was diagnosed with degenerative dessiation, L3-4 and L405 with right lower extremity radiculitis. A claim was placed for multiple medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl 50 mcg #15 with one refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system) Page(s): 74-82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79.

Decision rationale: Fentanyl 50 mcg #15 with one refill is not medically necessary. Per MTUS Page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain

with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. In fact, the medical records note that the claimant was permanent and stationary. The claimant has long-term use with this medication and there was a lack of improved function with this opioid; therefore the requested medication is not medically necessary. It is more appropriate to wean the claimant off opioids with a short course of short acting opiates.

Percocet 10/325 mg, #90 with one refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79.

Decision rationale: Percocet 10/325 mg, #90 with one refill is not medically necessary. Per MTUS Page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. In fact, the medical records note that the claimant was permanent and stationary. The claimant has long-term use with this medication and there was a lack of improved function with this opioid; therefore the requested medication is not medically necessary.

Zoloft 50 mg, #90 with five refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13.

Decision rationale: Zoloft 50 mg, #90 with five refills is not medically necessary. CA MTUS page 13 states that antidepressants are recommended as first-line option for neuropathic pain, as a possibility for non-neuropathic pain. Tricyclics are generally considered first line agent unless they're ineffective, poorly tolerated, or contraindicated. Zoloft is a selective serotonin reuptake inhibitor. Per CA MTUS SSRIs is a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline and are controversial based on controlled trials. It is been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. More information is needed regarding the role of SSRIs and pain. The medical records do not appropriately address whether the claimant has depression associated

with chronic pain through psychological evaluation. Additionally there was not documentation that the enrollee failed Tricyclics which is recommended by CA MTUS as first line therapy.