MAXIMUS Federal Services

Case Number:	CM14-0188758		
Date Assigned:	11/19/2014	Date of Injury:	01/11/2010
Decision Date:	01/07/2015	UR Denial Date:	10/20/2014
Priority:	Standard	Application Received:	11/12/2014

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, 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 41 year old female with date of injury 1/11/10. The treating physician report dated 9/19/14 indicates that the patient presents with pain affecting cervical pain and upper extremity pain. The physical examination findings reveal scalene spasm/dystonia bilaterally and decreased sensation to touch and pin in BUE's (lower trunk worse). There is Positive Adson's bilaterally. The current diagnoses are: 1.Brachial plexus lesions2.Reflx sympathet dystrophy up limb3.Loc osteoarthrosis-shldr region4.Displcmt cerv disc w/o myelopathy5.Degen cerv intervertebral disc6.Brachial neuritis/radiculitis nos The utilization review dated 10/20/14 denied the request for Percocet, Ambien CR, Imitrex, Celebrex, Flexeril, and Protonix based on lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

percocet 10/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-96.

Decision rationale: The patient presents with cervical and upper extremity pain. The current request is for Percocet 10/325mg #60. Per the reports provided it is unclear as to when the patient began taking this medicine, however it is stated on a report dated 04/15/14 that the patient was receiving a refill of the medication indicating a start date prior to 04/15/14. The report dated 9/19/14 lists it as a continuing medication. MTUS Guidelines page 88 and 89 require functioning documentation using a numerical scale or validated instrument at least one every six months, documentation of the 4A's (analgesia, ADLs, adverse side effect, adverse behavior) is required. Furthermore, under outcome measure, it also recommends documentation of chronic pain, average pain, least pain, the time it takes for medication to work, duration of pain relief with medication etc. The treater does not use any numerical scales to the patient's pain and function specific to Percocet as required by MTUS. There are no discussion of the four A's, including specific improvements in ADL's. Given the lack of required documentation demonstrating efficacy for chronic opiate use, recommendation is for denial.

Ambien CR 12.5mg #9: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines and Mosby's Drug consult

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain

Decision rationale: The patient presents with cervical and upper extremity pain. The current request is for Ambien CR 12.5mg #9. Per the reports provided it is unclear as to when the patient began taking this medicine, however it is stated on a report dated 04/15/14 that the patient was receiving a refill of the medication indicating a start date prior to 04/15/14. The report dated 9/19/14 lists it as a continuing medication. The ODG guidelines state, "Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is recommended for short-term (7-10 days) treatment of insomnia." The MTUS guidelines are silent on Ambien. Ambien is being prescribed for a short course as required by the ODG. Recommendation is for approval.

Imitrex 100mg #9: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Online Head Chapter

Decision rationale: The patient presents with cervical and upper extremity pain. The current request is for Imitrex 100mg #9. Per the reports provided it is unclear as to when the patient began taking this medicine, however it is stated on a report dated 09/19/14 that the patient was receiving a refill of the medication indicating a start date prior to that. The report dated 04/15/14 does not list it as a continuing medication. The ODG guidelines recommend Imitrex (Triptans)

for migraine sufferers. In this case the treating physician has indicated in their report dated 9/19/14 that the patient still suffers 2-3 migraines a week after receiving additional treatment methods. The MTUS guidelines page 60 require that the physician document pain and function and page 8 states, "Continuation or modification of pain management depends on the physician's evaluation of progress toward treatment objectives. The treating physician has failed to document any relief or functional improvement with Imitrex usage. Recommendation is for denial.

Celebrex 200mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-70.

Decision rationale: The patient presents with cervical and upper extremity pain. The current request is for Celebrex 200mg #60. Per the reports provided it is unclear as to when the patient began taking this medicine, however it is stated on a report dated 04/15/14 that the patient was receiving a refill of the medication indicating a start date prior to 04/15/14. The report dated 9/19/14 lists it as a continuing medication. The MTUS Guidelines state, "Recommended as an option for short-term symptomatic relief." In this case the patient has been prescribed this medication for over six months. The MTUS guidelines page 60 require that the physician document pain and function and page 8 states, "Continuation or modification of pain management depends on the physician's evaluation of progress toward treatment objectives. The treating physician has failed to document any relief or functional improvement with Celebrex usage. Recommendation is for denial.

Flexeril 5mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: The patient presents with cervical and upper extremity pain. The current request is for Flexeril 5mg #60. Per the reports provided it is unclear as to if/when the patient began taking this medicine, as it is not listed as a continuing medication on either the 9/19/14 or the 04/15/14 report. MTUS guidelines page 64 state the following, " Cyclobenzaprine is recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. " MTUS guidelines for muscle relaxant for pain page 63 state, "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP." MTUS does not recommend more than 2 to 3 weeks for use of the medication. In this case the request is for one-month

supply. The guidelines do not support use of this medication in its current requested quantity. Recommendation is for denial.

Protonix 20mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 69.

Decision rationale: The patient presents with cervical and upper extremity pain. The current request is for Protonix 20mg #60. Per the reports provided it is unclear as to if/when the patient began taking this medicine, as it is not listed as a continuing medication on either the 9/19/14 or the 04/15/14 report. The MTUS guidelines support the usage of Proton Pump Inhibitors (PPIs) for gastric side effects due to NSAID use. ODG also states that PPIs are recommended for patients at risk for gastrointestinal events. In this case the treating physician has not documented that the patient suffers with any G/I symptoms. Recommendation is for denial.