

Case Number:	CM15-0007815		
Date Assigned:	01/16/2015	Date of Injury:	10/27/2011
Decision Date:	03/13/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/14/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 53 year old female, who sustained an industrial injury on October 27, 2011. She has reported psychological issues, head and neck pain, sleep disturbances, right arm pain, and low back and leg pain. The diagnoses have included radiculopathy, low back pain and lumbar degenerative disc disease (DDD). Treatment to date has included back brace, electromyogram, nerve conduction velocity (NCV) and oral medication. Currently, the IW complains of low back pain radiating down right leg with numbness tingling and spasms. She states her function is improved with medication per primary treating physician visit dated November 17, 2014. Treatment includes oral medications. On December 23, 2014 utilization review non-certified a request for Effexor XR 75mg, Percocet 10325mg, Cymbalta 60mg quantity 30 refill 3, Lactulose 10gm/15ml solution quantity 450 refill 3. The Medical Treatment Utilization Schedule (MTUS) guidelines were utilized in the determination. Application for independent medical review (IMR) is dated December 27, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Effexor XR 75mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressant for Chronic Pain, 13-16.

Decision rationale: MTUS Medical Treatment Guidelines do not recommend Effexor, a Selective Serotonin and Norepinephrine ReUptake Inhibitor (SSRI/SNRIs) without evidence of failed treatment with first-line tricyclics (TCAs) not evident here. Tolerance may develop and rebound insomnia has been found as for this patient who has sleeping complaints. An SSRI/SNRI may be an option in patients with coexisting diagnosis of major depression that is not the case for this chronic injury of 2011 without remarkable acute change or red-flag conditions. Submitted reports from the provider have not adequately documented any failed trial with first-line TCAs nor is there any diagnosis of major depression. The patient has been prescribed the medication without any functional improvement derived from treatment already rendered. The Effexor XR 75mg is not medically necessary and appropriate.

Percocet 10/345mg. Qty. 120: Upheld

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

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

Decision rationale: Per the MTUS Guidelines cited, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial. Patients on opioids should be routinely monitored for signs of impairment and use of opioids in patients with chronic pain should be reserved for those with improved functional outcomes attributable to their use, in the context of an overall approach to pain management that also includes non-opioid analgesics, adjuvant therapies, psychological support, and active treatments (e.g., exercise). Submitted documents show no evidence that the treating physician is prescribing opioids in accordance to change in pain relief, functional goals with demonstrated improvement in daily activities, decreased in medical utilization or change in functional status. There is no evidence presented of random drug testing or utilization of pain contract to adequately monitor for narcotic safety, efficacy, and compliance. The MTUS provides requirements of the treating physician to assess and document for functional improvement with treatment intervention and maintenance of function that would otherwise deteriorate if not supported. From the submitted reports, there is no demonstrated evidence of specific functional benefit derived from the continuing use of opioids with persistent severe pain for this chronic injury without acute flare, new injury, or progressive deterioration. The Percocet 10/345mg. Qty. 120 is not medically necessary and appropriate.

Cymbalta 60mg. Qty. 30 Refill:3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressant for Chronic Pain, 13-16.

Decision rationale: MTUS Medical Treatment Guidelines do not recommend Cymbalta, a Selective Serotonin and Norepinephrine ReUptake Inhibitor (SSRI/SNRIs) without evidence of failed treatment with first-line tricyclics (TCAs) not evident here. Tolerance may develop and rebound insomnia has been found as for this patient who has sleeping complaints. An SSRI/SNRI may be an option in patients with coexisting diagnosis of major depression that is not the case for this chronic injury of 2011 without remarkable acute change or red-flag conditions. Submitted reports from the provider have not adequately documented any failed trial with first-line TCAs nor is there any diagnosis of major depression. The patient has been prescribed the medication without any functional improvement derived from treatment already rendered. The Cymbalta 60mg. Qty. 30 Refill:3 is not medically necessary and appropriate.

Lactulose 10gm/15ml Solution Qty. 450 Refill:3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS, Pages 77, 88.

Decision rationale: Lactulose is a synthetic disaccharide in solution form for oral or rectal administration and is a colonic acidifier for treatment and prevention of portal-systemic encephalopathy, including the stages of hepatic pre-coma and coma not identified here. It is unclear how this medication would be prescribed for this patient with chronic injury. Submitted reports have not demonstrated clear clinical findings and diagnosis for this medication. The Lactulose 10gm/15ml Solution Qty. 450 Refill:3 is not medically necessary and appropriate.