

Case Number:	CM15-0103753		
Date Assigned:	06/08/2015	Date of Injury:	11/04/1999
Decision Date:	07/10/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	05/29/2015

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: Preventive Medicine, Occupational Medicine

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 41-year-old female, who sustained an industrial injury on 11/04/1999. Initial complaints and diagnosis were not clearly documented. On provider visit dated 03/18/2015 the injured worker has reported bilateral neck and lumbar spasms. On examination, the injured worker also complained of bilateral wrist pain. The cervical spine was noted as having bilateral paracervical tenderness with a decreased range of motion. Lumbar spine was reported to have bilateral paralumbar tenderness and spasms. Motor exams noted bilateral cervical and lumbar spasms. The diagnoses have included degenerative disc disease- lumbar, neck sprain/strain, thoracic outlet syndrome and reflex sympathetic dystrophy. Treatment to date has included physical therapy home exercise program and medication that include medications: Oxycontin, Oxycodone HCL, Topamax, Flector, Trazodone, cyclobenzaprine HCL and topical Gaba/Lido/Keta gel. The provider requested Oxycodone HCL, Oxycontin 80mg, Cyclobenzaprine 10mg and Topical Gel: Gaba/Lido/Ketamine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone HCL 30 MG Qty 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792. 20 - 9792. 26 Page(s): 74-94.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Oxycodone HCL, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. Oxycodone HCL 30 MG Qty 60 is not medically necessary.

Oxycontin 80 MG Qty 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792. 20 - 9792. 26 Page(s): 74-94.

Decision rationale: According to the MTUS in regard to medications for chronic pain, only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. A record of pain and function with the medication should be recorded. According to this citation from the MTUS, medications should not be initiated in a group fashion, and specific benefit with respect to pain and function should be documented for each medication. There is no documentation of the above criteria for either of the narcotics that the patient has been taking. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. Oxycontin 80 MG Qty 120 is not medically necessary.

Cyclobenzaprine 10 MG Qty 240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792. 20 - 9792. 26 Page(s): 64.

Decision rationale: The MTUS Chronic Pain Treatment Guidelines do not recommend long-term use of muscle relaxants such as cyclobenzaprine. The patient has been taking cyclobenzaprine for an extended period. The patient has been prescribed a quantity of cyclobenzaprine that greater than the amount necessary for a 2-3 week course recommended by the MTUS. Cyclobenzaprine 10 MG Qty 240 is not medically necessary.

Topical Gel : Gaba 6 Percent, Lido 5 Percent, Ketamine 10 Percent 60 Gram: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792. 20 - 9792. 26 Page(s): 111.

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended. There is no peer-reviewed literature to support use. Topical Gel : Gaba 6 Percent, Lido 5 Percent, Ketamine 10 Percent 60 Gram is not medically necessary.