

Case Number:	CM15-0168390		
Date Assigned:	09/09/2015	Date of Injury:	09/03/2002
Decision Date:	10/23/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	08/26/2015

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, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 59 year old female with a date of injury on 9-3-2002. A review of the medical records indicates that the injured worker is undergoing treatment for chronic pain, lumbar radiculopathy, right hip pain, right shoulder pain, anxiety and status post right shoulder surgery with residuals. Medical records (4-15-2015 to 8-5-2015) indicate ongoing neck pain radiating down the bilateral upper extremities. She complained of frequent muscle spasms in the neck area. She complained of low back pain radiating down the bilateral lower extremities. She rated her average pain as 7 to 8 out of 10 with medication and 10 out of 10 without medication. She reported severe difficulty in sleep and medication associated gastrointestinal upset. She reported ongoing limitations in activities of daily living. Per the treating physician (8-5-2015), the employee has not returned to work. The physical exam (4-15-2015 to 8-5-2015) reveals continuing decreased lumbar range of motion. There was tenderness and spasm in the lumbar spine area. There was tenderness to palpation at the right shoulder and right hip. Treatment has included magnetic resonance imaging (MRI), surgery, psychotherapy, and medications. Documentation indicates that the injured worker has been prescribed Fentanyl, Norco, Omeprazole and Fluoxetine since at least January 2015. Notes indicate the patient has a Back Depression Inventory score of 50 indicating depression. The note also indicates that an NDI assessment indicates that the patient is bedbound. CURES was consistent. The note indicates that the patient was seeing a psychiatrist who left the practice and she has been unable to get her Prozac renewed. She will be out of Prozac soon. The notes go on to state that the opioid analgesic has allow the patient to increase/maintain activities of daily living and function and

has been well tolerated with no adverse effects. A pain contract is on file in the patient is undergoing regular testing. The original Utilization Review (UR) (8-11-2015) modified a request for Fentanyl 12 mcg patches #10 to #5. UR modified a request of Hydroco-Apap 10-300mg #90 to #45. UR modified a request for Omeprazole DR 20mg #30 to # 15. UR modified a request for Fluoxetine 20mg #30 to #15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl 12mcg patch #10: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment.

Decision rationale: Regarding the request for Fentanyl 12mcg patch #10, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's function and pain with no intolerable side effects or aberrant use, and the patient is noted to undergo monitoring. In light of the above, the currently requested Fentanyl 12mcg patch #10 is medically necessary.

Hydroco/Apap 10/300mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment.

Decision rationale: Regarding the request for Hydroco/Apap 10/300mg #90, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse

potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's function and pain with no intolerable side effects or aberrant use, and the patient is noted to undergo monitoring. In light of the above, the currently requested Hydroco/Apap 10/300mg #90 is medically necessary.

Omeprazole DR 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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, Proton Pump Inhibitors (PPIs).

Decision rationale: Regarding the request for omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested omeprazole (Prilosec) is not medically necessary.

Fluoxetine 20mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Stress-Related Conditions 2004, Section(s): Initial Assessment, Treatment, and Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain, SSRIs (selective serotonin reuptake inhibitors).

Decision rationale: Regarding the request for Fluoxetine 20mg #30, Chronic Pain Medical Treatment Guidelines state that selective serotonin reuptake inhibitors may have a role in treating secondary depression. Additionally, guidelines recommend follow-up evaluation with mental status examinations to identify whether depression is still present. Guidelines indicate that a lack of response to antidepressant medications may indicate other underlying issues. Within the documentation available for review, it is clear the patient has a diagnosis of depression confirmed by testing. Additionally, the patient has lost their psychiatrist and the primary treating physician is prescribing the antidepressant until a new psychiatrist can be found. It is acknowledged, that there should be better documentation of benefit from fluoxetine. However, a one-month prescription as requested here should allow the requesting physician time to better document that item. As such, the currently requested Fluoxetine 20mg #30 is medically necessary.