

Case Number:	CM15-0180074		
Date Assigned:	09/21/2015	Date of Injury:	01/03/1985
Decision Date:	10/30/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/14/2015

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, Hawaii

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 72 year old male, who sustained an industrial injury on January 3, 1985. Medical records indicate that the injured worker is undergoing treatment for thoracic disc herniation, intractable back pain, lumbar radiculitis and status-post multiple lumbar spine surgeries. The injured worker was noted to be permanent and stationary. Current documentation dated August 20, 2015 notes that the injured worker was still debilitated status-post revision fusion and decompression. The injured worker was noted to have improvement in symptoms post-surgery. However, after a significant fall he had a new onset of pain and numbness with imbalance. The injured worker continues to have imbalance with persistent foot numbness and pain on the left side. Objective findings revealed weakness in the left tibialis anterior and extensor hallucis longus muscle of 4-5. The injured worker has imbalance when he walks heel to toe. Treatment and evaluation to date has included medications, electrodiagnostic studies, MRI of the thoracic spine (7-27-2015), x-rays of the thoracic spine (6-18-2015), computed tomography scan of the lumbar spine (5-28-2015), epidural steroid injections, acupuncture treatments, chiropractic treatments, physical therapy and a Thoraco-Lumbar-Sacral Orthosis Brace (TLSO). Surgeries include lumbar laminectomies in 1985 and 1991, lumbar fusions in 1999 and 2003 and a revision of a fusion and decompression in 2015. Current medications include Cymbalta (since at least December of 2013), Gabapentin (since at least December of 2013), Bupropion, Percocet (since at least July of 2015) and Viagra. Current requested treatments include requests for Percocet 10-325 mg # 90, Cymbalta 30 mg # 30 and Gabapentin 400 mg # 90. The Utilization Review documentation dated September 8, 2015 non-certified the requests for Percocet 10-325 mg # 90, Cymbalta 30 mg # 30 and Gabapentin 400 mg # 90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #90: Upheld

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, criteria for use.

Decision rationale: The patient presents with pain affecting the low back. The current request is for Percocet 10/325mg #90. The requesting treating physician report dated 9/3/15 (132C) provides no rationale for the current request. MTUS pages 88 and 89 states "document pain and functional improvement and compare to baseline. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS also requires documentation of the four A's (analgesia, ADL's, Adverse effects and Adverse behavior). The medical reports provided show the patient has been taking Percocet since at least 7/28/15 (244C). The report dated 9/3/15 (132C) does not note that the patient's current pain level. No adverse effects or adverse behavior were discussed by the patient. The patient has not returned to work. The patient's last urine drug screen was not available for review and there is no evidence provided that shows the physician has a signed pain agreement or cures report on file. In this case, all four of the required A's are not addressed, the patient's pain level has not been assessed at each visit and functional improvement has not been documented. The MTUS guidelines require much more thorough documentation to recommend the continued usage of Percocet. The current request is not medically necessary.

Cymbalta 30mg #30: Upheld

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): SNRIs (serotonin noradrenaline reuptake inhibitors).

Decision rationale: The patient presents with pain affecting the low back. The current request is for Cymbalta 30mg #30. The requesting treating physician report dated 9/3/15 (132C) provides no rationale for the current request. MTUS page 43-44 state that Duloxetine (Cymbalta) "Recommended as an option in first-line treatment option in neuropathic pain." It has FDA approval for treatment of depression, generalized anxiety disorder, and for the treatment of pain related to diabetic neuropathy. In this case, while the current request may be medically necessary, there is no documentation of functional improvement or discussion of this medication's efficacy in any of the current medical reports provided for review, as required by the MTUS guideline on page 60. The current request is not medically necessary.

Gabapentin 400mg #90: Upheld

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): Anti-epilepsy drugs (AEDs).

Decision rationale: The patient presents with pain affecting the low back. The current request is for Gabapentin 400mg #90. The requesting treating physician report dated 9/3/15 (132C) provides no rationale for the current request. The MTUS guidelines support the usage of Gabapentin for the treatment of radicular pain. In this case, while the current request may be medically necessary, there is no documentation of functional improvement or discussion of this medication's efficacy in any of the current medical reports provided for review, as required by the MTUS guidelines on page 60. The current request is not medically necessary.