

Case Number:	CM15-0022081		
Date Assigned:	02/11/2015	Date of Injury:	05/12/2005
Decision Date:	04/03/2015	UR Denial Date:	01/24/2015
Priority:	Standard	Application Received:	02/05/2015

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: Pennsylvania

Certification(s)/Specialty: Internal Medicine, Hospice & Palliative 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:

This 51 year old male sustained an industrial injury on 5/12/05, with subsequent ongoing back and neck pain. In a pain medicine reevaluation dated 12/30/14, the injured worker complained of neck pain with radiation down bilateral upper extremities and lumbar spine with radiation down bilateral lower extremities. The injured worker rated his pain 6/10 on the visual analog scale and 10/10 without medications. Physical exam was remarkable for tenderness to palpation in the thoracic and lumbar spine and coccyx, decreased range of motion to the lumbar spine that increased with bending, flexion and extension, decreased sensation to pinpoint along the L4-S1 of the left lower extremity, decreased strength to the left lower extremity and positive straight leg raise to bilateral lower extremities. The injured worker was unable to heel walk or toe walk. Babinski was up-going on the right. Current diagnoses included lumbar disc degeneration, lumbar radiculopathy, coccyx pain, diabetes mellitus, Parkinson's syndrome and NSAID intolerance. The treatment plan included continuing medications Amitriptyline, Morphine ER and Voltaren Gel. On 1/23/15, Utilization Review modified a request for Morphine Sulfate ER 15mg, #60 to Morphine Sulfate ER 15mg, #45 and non-certified a request for Amitriptyline 25mg, #30 and Voltaren 1% Gel, #300 noting ongoing insomnia despite treatment and citing CA MTUS Chronic Pain Medical Treatment Guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitriptyline 25mg, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13-15.

Decision rationale: Amitriptyline is a medication in the tricyclic antidepressant class. The MTUS Guidelines recommend tricyclic antidepressants as first line agents against neuropathic pain unless the therapy is ineffective, poorly tolerated, or not able to be given for medical reasons. Analgesia generally occurs within a few days while the antidepressant effects tend to take longer. Efficacy should be assessed based on pain outcomes, functional improvement, decreased use of other pain medications, mood and psychiatric symptoms, and side effects. The submitted and reviewed records indicate the worker was experiencing pain in the upper back that went into the arms, lower back pain that went into the legs, and depressed mood. The documented pain assessments did not detail what benefit the worker experienced from this medication, and there was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for thirty tablets of amitriptyline 25mg is not medically necessary. Because the potentially serious risks outweigh the benefits in this situation based on the submitted documentation, an individualized taper should be able to be completed with the medication the worker has available.

Morphine Sulfate ER 15mg, #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Weaning of Medications Page(s): 74-95, 124.

Decision rationale: Long-acting morphine is a medication in the opioid class. The MTUS Guidelines stress the lowest possible dose of opioid medications should be prescribed to improve pain and function, and monitoring of outcomes over time should affect treatment decisions. Documentation of pain assessments should include the current pain intensity, the lowest intensity of pain since the last assessment, the average pain intensity, pain intensity after taking the opioid medication, the amount of time it takes to achieve pain relief after taking the opioid medication, the length of time the pain relief lasts. An ongoing review of the overall situation should be continued with special attention paid to the continued need for this medication, potential abuse or misuse of the medication, and non-opioid methods for pain management. Acceptable results include improved function, decreased pain, and/or improved quality of life. The MTUS Guidelines recommend opioids be continued when the worker has returned to work and if the worker has improved function and pain control. Consideration for consultation with a multidisciplinary pain clinic or weaning off the medication is encouraged if the pain does not

improve with opioid therapy within three months or when these criteria are not met. An individualized taper of medication is recommended to avoid withdrawal symptoms. The submitted and reviewed documentation indicated the worker was experiencing pain in the upper back that went into the arms, lower back pain that went into the legs, and depressed mood. While these records did not provide an individualized risk assessment, the most recent pain assessment did describe improved pain intensity and function with this medication and explored the potential negative effects. In light of this supportive evidence, the current request for sixty tablets of long-acting morphine 15mg is medically necessary.

Voltaren 1% Gel, #300: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The MTUS Guidelines recommend topical NSAIDs to treat pain due to osteoarthritis and tendonitis but not neuropathic pain. Use is restricted to several weeks because benefit decreases with time. It is specifically not recommended for use at the spine, hip, or shoulder areas. Diclofenac 1% is the medication and strength approved by the FDA. The submitted and reviewed documentation indicated the worker was experiencing pain in the upper back that went into the arms, lower back pain that went into the legs, and depressed mood. The documented pain assessments and examinations suggested this medication was being used at least primarily for a neuropathic pain. There was no discussion suggesting special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for 300g of Voltaren (diclofenac) 1% gel is not medically necessary.