

Case Number:	CM15-0084805		
Date Assigned:	05/07/2015	Date of Injury:	09/20/2007
Decision Date:	09/14/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/04/2015

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 56 year old female, who sustained an industrial injury on 9/20/2007. She reported being struck in the back by a door resulting in acute back pain and developing pain in the neck, mid and low back, knees right leg and right elbow. Diagnoses include fibromyalgia, cervical disc herniation, thoracic disc herniation, and lumbar facet arthropathy and degenerative disc disease. She is status post cervical spine surgery in 2011 and a lumbar fusion in 2012. Treatments to date include medication therapy, physical therapy, chiropractic therapy, acupuncture treatments, therapeutic injections and a TENS unit. Currently, she complained of neck pain and low back pain both rated 10/10 VAS. On 3/26/15, the physical examination documented decreased range of motion in the cervical and lumbar spines. There was tenderness in the lumbar muscles and facet joints. The diagnoses included status post cervical discectomy and fusion, lumbar fusion, and chronic pain. The plan of care included OxyContin 40mg one tablet twice a day #60, Percocet 10/325mg one every four to six hours #120, Robaxin 750mg one twice a day, #60, Lyrica 100mg twice a day #60, Cymbalta 60mg one daily #30, and a thirty day rental Interferential unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 40mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 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 Oxycontin, 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. Oxycontin 40mg #60 is not medically necessary.

Percocet 10/325mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 92.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 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. Percocet 10/325mg #120 is not medically necessary.

Robaxin 750mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

Decision rationale: The MTUS states that muscle relaxants are recommended with caution only on a short-term basis. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. The patient has been taking the muscle relaxant for an extended period of time far longer than the short-term course recommended by the MTUS. Robaxin 750mg #60 is not medically necessary.

Lyrica 100mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-17, 19-20.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19-20.

Decision rationale: The MTUS states that Lyrica has FDA approval for painful diabetic neuropathy, postherpetic neuralgia, and fibromyalgia. The patient does carry a diagnosis of fibromyalgia. The clinical information submitted for review meets the evidence based guidelines for the requested service. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly. I am reversing the previous utilization review decision. Lyrica 100mg #60 is medically necessary.

Cymbalta 60mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 14, 105.

Decision rationale: Recommended as an option in depressed patients for non-neuropathic pain, but effectiveness is limited. The medical record fails to document depression secondary to chronic pain. The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. At present, based on the records provided, and the evidence-based guideline review, the request is non-certified. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly. Cymbalta 60mg #30 is not medically necessary.

Interferential Unit for 30 days #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: The MTUS does not recommend a TENS unit as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. There is documentation that a previous trial period with a rented TENS unit has been completed but no functional improvement was noted. Rental of an additional TENS unit is not appropriate. Interferential Unit for 30 days #1 is not medically necessary.

