

Case Number:	CM15-0089131		
Date Assigned:	05/13/2015	Date of Injury:	11/14/2001
Decision Date:	09/22/2015	UR Denial Date:	04/13/2015
Priority:	Standard	Application Received:	05/08/2015

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 59 year old female, who sustained an industrial injury on 11/14/2001. On provider visit dated 04/02/2015 the injured worker has reported chronic lower extremity pain, bilateral knee pain, and low back pain. On examination the injured worker was noted to complain of ongoing back pain to right more than left side, pain was noted to be worse on standing; knees were noted to be tender and to have pain on range of motion. The injured worker was noted to have symptoms of restless leg syndrome due to neuropathic pain. The diagnoses have included spasm of muscle, pain in joint, lower leg, other and unspecified derangement medial meniscus, unspecified myalgia and myositis, and pain in joint, ankle and foot. Treatment to date has included medication, physical therapy, med management and home exercise program. The provider requested Cymbalta 60mg #60, Neurontin 800mg #120, Fentanyl patch, Prilosec, Trazodone 25mg #30 and PC5001 compound cream 150gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta 60mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 15.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 14, 105.

Decision rationale: Recommended as an option in depressed patients for non-neuropathic pain, but effectiveness is limited. The examination findings provided no objective or quantitative measure of pain to determine severity. 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. Cymbalta 60mg #60 is not medically necessary.

Neurontin 800mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 19.

Decision rationale: The MTUS states that gabapentin is an anti-epilepsy drug which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. An adequate trial period for gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. With each office visit the patient should be asked if there has been a change in the patient's pain symptoms, with the recommended change being at least 30%. There is no documentation of any functional improvement. Neurontin 800mg #120 is not medically necessary.

Fentanyl patch 50.ugm #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 113.

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. Fentanyl is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. There is no documentation supporting any functional improvement with the continued long-term use of opioids. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. Fentanyl patch 50.ugm #10 is not medically necessary.

Prilosec: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 68.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor Prilosec. Prilosec is not medically necessary.

Trazodone 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, Mental Illness & Stress / Trazodone (Desyrel).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Antidepressants for chronic pain.

Decision rationale: Trazodone is a tetracyclic antidepressant used to treat depression and anxiety disorders. The Official Disability Guidelines recommend numerous antidepressants in a number of classes for treating depression and chronic pain. Trazodone is not contained within the current recommendations by the ODG. Trazodone 25mg #30 is not medically necessary.

PC5001 150gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 111-113.

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. There is no peer-reviewed literature to support use. PC5001 150gm is not medically necessary.