

Case Number:	CM14-0121260		
Date Assigned:	09/16/2014	Date of Injury:	03/09/2001
Decision Date:	10/31/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	07/31/2014

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. The expert reviewer is Board Certified in Internal Medicine, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 73 year old female injured on 03/09/2001 resulting from repetitive heavy lifting resulting in low back pain. Treatment to date includes multiple lumbar surgeries, chiropractic therapy, physical therapy, medication management, spinal cord stimulator, and diagnostic studies. Diagnoses include chronic opioid use, depressive disorder, cervical discopathy, failed back syndrome, musculoligamentous of the lumbosacral thoracic spine, and status post repair of compression fracture at T7. Clinical note dated 02/18/14 indicates the injured worker presented for evaluation of chronic low back pain and medication management. The injured worker recently notified Valium, Lidoderm and OxyContin no longer to be covered by workers compensation therefore, no longer taking OxyContin 20 mg bid; however, continued to take Valium 10 mg qid and Celexa 20 mg qd. Lidoderm patches were reported beneficial. The injured worker reported request to have spinal cord stimulator removed. Treatment plan included switch from OxyContin to oxycodone 20 mg bid and continued use of Valium, transdermal analgesic ointment and Celebrex. Clinical note dated 08/14/14 reports worsening pain over bilateral buttock area radiating to posterior and lateral aspect of bilateral thigh with numbness and tingling. An increase in pain is reported when standing on uneven surfaces or climbing stairs. Ongoing to complain of lumbar pain with no relief from spinal cord stimulator placement reported. Objective findings included severe sacroiliac joint inflammation with symptoms of radiculitis/radiculopathy to posterior and lateral aspect of thigh, Gaenslen's test and Patrick-Faber test positive, sacroiliac joint thrust demonstrated severely positive. The injured worker requesting switch to [REDACTED] brand stimulator with removal of [REDACTED]. The injured worker scheduled for bilateral sacroiliac joint injection on 08/20/14. Prescription for Terocin patch and Terocin lotion provided. The initial request was non-certified on 07/22/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 20 mg tablets request for 2 months #30 refill: 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided to include individual activities of daily living, community activities, and exercise able to perform as a result of medication use. Additionally, the documentation indicated a worsening of symptoms following initiation of the medication indicating a lack of efficacy. As such, Oxycodone 20 mg tablets request for 2 months #30 refill: 1 cannot be recommended as medically necessary at this time.

Valium 10 mg tablets request for 2 months #120 refill:1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: As noted on page 24 of the Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use due to lack of proven efficacy with prolonged use and the risk of dependence. Most guidelines limit use to 4 weeks. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to effects develops rapidly. The patient has exceeded the 4 week treatment window. As such, the request for Valium 10 mg tablets request for 2 months #120 refill:1 cannot be recommended at this time.

Celexa 20 mg tablets request for 2 months #30 refill: 1: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines SSRIs (selective serotonin reuptake inhibitors) Page(s): 107.

Decision rationale: As noted on page 107 of the Chronic Pain Medical Treatment Guidelines, SSRIs are not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. The patient has been diagnosed and exhibits symptoms associated with depression requiring medication management. As such, the request for Celexa 20 mg tablets request for 2 months #30 refill: 1 is recommended as medically necessary at this time.

Neurontin 600 mg tablets request for 2 months #60 refill 1: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 49.

Decision rationale: As noted on page 49 of the Chronic Pain Medical Treatment Guidelines, current guidelines recommend Gabapentin for the treatment of neuropathic pain. The clinical documentation establishes the presence of objective findings consistent with neuropathy. As such, the request for Neurontin 600 mg tablets request for 2 months #60 refill 1 is recommended as medically necessary.

Neurontin 600mg #60 no refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 49.

Decision rationale: The previously addressed request for Neurontin 600 mg tablets request for 2 months #60 refill 1 was recommended as medically necessary. Additional prescriptions for Neurontin would be a redundancy in medication administration and therefore not medically necessary. There is no indication that the request was to be reviewed as retrospective. As such, the request for Neurontin 600mg #60 no refills cannot be recommended as medically necessary.