

Case Number:	CM14-0123359		
Date Assigned:	09/24/2014	Date of Injury:	12/01/2006
Decision Date:	10/31/2014	UR Denial Date:	07/07/2014
Priority:	Standard	Application Received:	08/04/2014

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 Physical Medicine and Rehabilitation 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 47-year-old female who reported an injury on December 01, 2006. The mechanism of injury was not submitted for clinical review. The diagnoses included cervical pain, disc disorder of the cervical spine, spasm of muscle, joint pain-shoulder, cervical disc degeneration, cervical radiculopathy, mood disorder. The previous treatments included medication, epidural steroid injections, and trigger point injections. The diagnostic testing included an MRI. In the clinical note dated March 27, 2014, it was reported the injured worker complained of neck, upper back, and right shoulder pain. On the physical exam, the provider noted the injured worker had restricted range of motion of the cervical spine with flexion at 45 degrees, and extension at 30-degrees, and limited by pain. On the examination of the paravertebral muscles, the provider noted spasms and tenderness on both sides. Tenderness was noted in the paracervical muscles, rhomboids, and trapezius. A positive Spurling's maneuver caused pain. There was a positive Hawkins test noted on the physical examination. There was tenderness to palpation in the acromioclavicular joint and supraspinatus and infraspinatus. The provider requested Cymbalta, Lidoderm, Rozerem, Soma, Nuvigil, Oxycontin, and Voltaren gel. However, a rationale was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Cymbalta (30mg, 1 daily, #30 with 1 refill, dispensed: 6/20/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cymbalta Page(s): 43.

Decision rationale: The retrospective request for Cymbalta is not medically necessary. The California MTUS Guidelines recommend Cymbalta as an option for first line treatment of neuropathic pain. It has FDA approval for the treatment of depression, generalized anxiety disorder, and for the treatment of pain related to diabetic neuropathy. The guidelines note antidepressants are recommended as an option for radiculopathy. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The clinical documentation submitted did not indicate the injured worker is treated for depression, generalized anxiety, or treatment of pain related to diabetic neuropathy. Therefore, the request is not medically necessary.

Retrospective request for Cymbalta (60mg, 1 daily, #30 with 1 refill, dispensed: 6/21/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cymbalta Page(s): 43.

Decision rationale: The retrospective request for Cymbalta is not medically necessary. The California MTUS Guidelines recommend Cymbalta as an option for first line treatment of neuropathic pain. It has FDA approval for the treatment of depression, generalized anxiety disorder, and for the treatment of pain related to diabetic neuropathy. The guidelines note antidepressants are recommended as an option for radiculopathy. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The clinical documentation submitted did not indicate the injured worker is treated for depression, generalized anxiety, or treatment of pain related to diabetic neuropathy. Therefore, the request is not medically necessary.

Retrospective request for Lidoderm 5% Patches (12-hrs on, 12-hrs off, #30, prescribed 6/18/2014): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

Decision rationale: The retrospective request for Lidoderm Patches is not medically necessary. The California MTUS Guidelines recommend topical NSAIDs for osteoarthritis and tendonitis,

in particular that of the knee and/or elbow and other joints that amenable. The guidelines note Lidoderm is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The clinical documentation submitted did not indicate the injured worker had tried and failed on anticonvulsants. Additionally, the request submitted failed to provide the treatment site. Therefore, the request is not medically necessary.

Retrospective request for Rozerem (8mg, 1 at bedtime, #30, prescribed 6/18/2014): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medline Plus, Ramelteon (Rozerem) and on the Official Disability Guidelines, Pain Chapter, Sedative Hypnotics, Insomnia Treatment

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

Decision rationale: The retrospective request for Rozerem is not medically necessary. The Official Disability Guidelines note that Rozerem is recommended for insomnia treatment. The guidelines also note it is recommended that treatment be based on etiology with the medication recommended. Pharmacological agents should be only used after careful evaluation of potential causes of sleep disturbances. Failure of sleep disturbances to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. There is lack of documentation indicating the injured worker is treated for insomnia. Additionally, there is lack of clinical documentation warranting the medical necessity for the request. Therefore, the request is not medically necessary.

Retrospective request for Soma (350mg, 1 tab - two times a day as needed, #60, prescribed 6/18/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63, 64.

Decision rationale: The retrospective request for Soma is not medically necessary. The California MTUS Guidelines recommend nonsedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbation in patients with chronic low back pain. The guidelines do not recommend the medication to be used for longer than 2 to 3 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The injured worker has been utilizing the medication since at least April 2014, which exceeds the guidelines recommendation of short-term use of 2 to 3 weeks. Therefore, the request is not medically necessary.

Retrospective request for Nuvigil (250mg, 1 daily, #30, prescribed 6/18/2014): 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 Chapter, Armodafinil (Nuvigil)

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

Decision rationale: The retrospective request for Nuvigil is not medically necessary. The Official Disability Guidelines do not recommend Nuvigil solely to counteract sedation effects of narcotics. It is used to treat excessive sleepiness caused by narcolepsy or shift work sleep disorder. There is lack of documentation indicting the efficacy of the medication as evidenced by significant functional improvement. There is lack of clinical documentation indicating the injured worker is treated for excessive sleepiness, narcolepsy, or shift work sleep disorder. Therefore, the request is not medically necessary.

Retrospective request for OxyContin (30mg, 3 tabs in am, 3 tabs in pm, max 6/day, prescribed 6/18/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Opioids, criteria for use

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: The retrospective request for OxyContin is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The provider failed to document an adequate and complete pain assessment within the documentation. Additionally, the use of a urine drug screen was not submitted for clinical review. Therefore, the request is not medically necessary.

Retrospective request for Voltaren 1% Gel (apply 2gms to affected body part, 2-3 times a day, 100gm tube, #3 with 1 refill, prescribed 6/18/2014): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

Decision rationale: The retrospective request for Voltaren Gel is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for osteoarthritis and tendonitis, in particular that of the knee and/or elbow and other joints that are amenable. The injured worker has been utilizing the medication since at least April 2014 with a lack of documentation indicating the medication had been providing objective functional benefit and improvement. Therefore, the request is not medically necessary.