

Case Number:	CM14-0091429		
Date Assigned:	07/25/2014	Date of Injury:	08/27/1998
Decision Date:	09/03/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	06/16/2014

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 & 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 51-year-old female who reported an injury on 08/27/1998. The mechanism of injury was not noted within the documentation submitted for review. Her diagnoses are noted to be bilateral occipital tension type headache, myofascial pain syndrome of the neck and bilateral shoulders, cervical spondylosis without myelopathy, low back pain, lumbar discogenic pain and lumbosacral spondylosis. Prior treatments were noted to be home exercises, medications and a weight loss program. Diagnostic testing was noted to be an MRI of the lumbar spine. Surgical history was noted to be intradiscal electro thermal annuloplasty for L4-5 and L5-S1. The injured worker had a clinical evaluation on 05/06/2014. It was noted that the injured worker had left sacroiliac pain and right knee pain. In addition, she reported left low back pain and cervical pain. The objective physical examination findings revealed moderate myofascial spasm and pain noted in the neck, bilateral shoulders and thoracic paravertebral muscles. Moderate bilateral occipital tenderness was noted. There was marked tenderness noted over the bilateral cervical facet joints. Cervical range of motion was decreased in all planes. Cervical extension and rotation provoked pain. Motor examination of the upper extremities was normal. Sensory examination of the bilateral upper extremities showed decreased sensation to light touch in the ulnar aspect of the bilateral forearms and bilateral 3rd, 4th, and 5th fingers. She was noted to use medications including baclofen, topiramate, Tizanidine, hydrocodone, and Pennsaid (topical diclofenac). The provider's rationale for the request was provided within the documentation submitted for review. A request for authorization form was not provided within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 5/325 mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid On-Going Management Page(s): 78.

Decision rationale: The request for oxycodone 5/325 mg quantity is 120 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines provide 4 domains that are relevant for ongoing monitoring of chronic pain patients on opioids these include pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. The clinical documentation should include pain relief, functional status, appropriate medication use and side effects. The clinical documentation submitted for review dated 05/06/2014 failed to provide an adequate pain assessment for opioid management. The pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improved quality of life. In addition, there was not a urine drug screen noted. The provider's request a dosage frequency. Therefore, the request for oxycodone 5/325 mg quantity 120 is not medically necessary.

Amrix 15 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 64.

Decision rationale: The request for Amrix 15 mg quantity 60 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines recommended Amrix for a short course of therapy for muscle spasms in conditions such as low back pain. The greatest effect appears in the first 4 days of treatment. The guidelines recommend dosing at 5 mg 3 times a day with an increase up to 10 mg 3 times a day. The provider's request for Amrix fails to provide a frequency. The dose of 15 mg is in excess of the guideline recommendations and the documentation fails to provide a treatment of 2 to 3 weeks. Therefore, the request for Amrix 15 mg quantity 60 is not medically necessary.

Topiramate 25 mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AED's).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Other Antiepileptic Drugs Page(s): page(s) 21.

Decision rationale: The request for topiramate 25 mg quantity 120 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines note topiramate has been shown to have variable efficacy with failure to demonstrate efficacy in neuropathic pain of central etiology. It is considered for use with neuropathic pain when other anticonvulsants fail. The documentation provided does not note use of other anticonvulsants that have failed thus requiring use for topiramate. In addition, the request for topiramate fails to provide a frequency. Therefore, the request for topiramate 25 mg quantity 120 is not medically necessary.

Pennsaid Topical Diclofenac #3 bottles: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Pennsaid® (diclofenac sodium topical solution).

Decision rationale: The request for Pennsaid topical diclofenac 3 bottles is not medically necessary. The Official Disability Guidelines do not recommend Pennsaid as a first line treatment. Diclofenac is recommended for osteoarthritis after failure of an oral NSAID or contraindications to an oral NSAID. Documentation provided does not indicate a failed trial of oral NSAIDs. It also does not provide a diagnosis of osteoarthritis. In addition, the provider's request does not indicate a usage frequency. Therefore, the request for Pennsaid topical diclofenac 3 bottles is not medically necessary.