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| Case Number: | CM14-0216649 | | |
| Date Assigned: | 01/06/2015 | Date of Injury: | 02/13/1990 |
| Decision Date: | 03/13/2015 | UR Denial Date: | 11/25/2014 |
| Priority: | Standard | Application Received: | 12/26/2014 |

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. 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: New York

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This male worker was injured on 02/13/1990 while being employed. On progress report dated 11/05/2014. He complained of pain in the following area: low back, down right leg left to calf area, left leg to knee, right hip, bilateral shoulders and neck. The injured workers diagnoses were noted as chronic pain syndrome following multiple lumbar spine surgeries, status post cervical laminectomy, status post sub acromial decompression-right shoulder, cervical radiculitis, status post implantable spinal cord stimulator, early carpal tunnel syndrome-right hand, diabetes, hypertension, depression, opiate addiction, sinus bradycardia, right elbow pain and swelling, and prostate cancer. Her past surgeries were noted as lumbar laminectomy with fusion L4-L5 with right iliac crest bone graft, hemilaminectomy on the right at L5 and foraminotomies at L5-S1, excision of the right shoulder os acromial, right shoulder acromioplasty, excision right shoulder lipoma, cervical laminectomy, fused L4-5 with hardware and right iliac crest bone, implanted spinal cord stimulator for pain, and pacemaker insertion. Her medication regimen was Zantac, Duragesic patch 125mg, Norco 10/325mg, Cymbalta 60mg, Skelaxin 800mg, Voltaren 1% Gel, Dicyclomine 10mg, Flector 1.3% patch, Tegaderm 4 inch to cover duragesic patch, Benzapril 20mg, Tenormin 100mg, Glucophage 500mg, Nasacort, Rythmol, Januvia 100mg, Actos 30mg, Simvastatin 10mg, Eliquis 2.5mg. There was no clear indicator of how these medications have been prescribed for. Work status was noted as permanent and stationary, 100% disabled, requires future medical care and is unemployable. On laboratory results of urine specimen on 9/10/2014 noted positive for Fentanyl and Norfentanyl. This review has two Utilization Review's (UR's) dated 11/26/2014. The first UR modified the request for Cymbalta 60mg capsule 1 daily #90 to

Cymbalta 60mg Capsule 1 daily to #60. The reviewing physician referred to CA MTUS Guidelines: Chronic Pain Medical Treatment Guidelines for recommendations. The second UR non-certified the request for Zantac 300mg tablet #90 twice per day, Bentyl 10mg Capsule #90 1x3 per day, Norco 10/325mg 2 every 8 hours #180, Skelaxin 800mg tablet 1 three x a day #270, Skelaxin 800mg tablet 1 three x a day #270, Durageic 50mcg/hr patch #15 and Voltaren 1% gel twice a day #18. The reviewing physician referred to MD Consult Drug Monograph guidelines for Zantac and Bentyl as CA MTUS does not address these specific requests. All other medication requests the physician used CA MTUS Guidelines: Chronic Pain Medical Treatment Guidelines and ODG for recommendations.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta 60mg cap 1 daily #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 43 - 44.

Decision rationale: The patient does not have documentation of diabetic neuropathy or fibromyalgia. He has been taking Cymbalta and there is no documented functional improvement. Cymbalta is not medically necessary for this patient.

Zantac 300mg tab #90 1 x twice per day: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Godlman's Cecil Medicine, 24th Edition. 2011.

Decision rationale: MTUS and ODG are silent about this topic. There is no documentation of peptic ulcer disease or GI bleeding. He has been taking Zantac without any functional improvement. There is insufficient documentation to substantiate the medical necessity of taking Zantac BID.

Bentyl 10mg cap #90, 1x3 per day: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63 - 66.

Decision rationale: Bentyl is a muscle relaxant and is being requested for 90 tablets to be used long term. MTUS, Chronic Pain, Muscle Relaxants, pages 63 - 66 notes that the long term use of muscle relaxants is not a recommended treatment. It is associated with mental and physical impaired abilities and has limited efficacy. The long term use of muscle relaxants is not a MTUS recommended treatment. Also, Bentyl is used to treat IBS and this diagnosis is not documented.

Norco 10-325mg t po q 8hrs, #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78 - 79.

Decision rationale: The documentation provided for review does not meet MTUS chronic pain, opiate on-going treatment criteria which includes documentation of analgesia, adverse effects, improved functionality in activities of daily living or return to work and monitoring for drug seeking abnormal behavior. Norco is not medically necessary.

Skelaxin 800mg tab 1 three x a day #270: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63 - 66.

Decision rationale: Skelaxin is a muscle relaxant. The request is for 270 tablets for long term use. MTUS, Chronic Pain, Muscle Relaxants page 63 - 66 notes that long term treatment with muscle relaxants is not a MTUS recommended treatment. Muscle relaxants are associated with impaired mental and physical abilities and limited long term efficacy. It is not medically necessary for this patient.

Skelaxin 800mg tab 1 three x a day #270: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63 - 66.

Decision rationale: Skelaxin is a muscle relaxant. The request is for 270 tablets for long term use. MTUS, Chronic Pain, Muscle Relaxants page 63 - 66 notes that long term treatment with

muscle relaxants is not a MTUS recommended treatment. Muscle relaxants are associated with impaired mental and physical abilities and limited long term efficacy. It is not medically necessary for this patient.

Duragesic 50mcg / hr patch #15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-going Management Page(s): 78 - 79.

Decision rationale: The documentation provided for review does not meet MTUS chronic pain, opiate on-going treatment criteria which includes documentation of analgesia, adverse effects, improved functionality in activities of daily living or return to work and monitoring for drug seeking abnormal behavior. Duragesic patch is not medically necessary.

Voltaren 1% gel twice a day, #18: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG-TWC)

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

Decision rationale: The patient had multiple spine surgeries and shoulder surgery. Voltaren Gel is not MTUS recommended treatment for spine, hip or shoulder. The use of Voltaren gel has not provided any functional improvement.