

Case Number:	CM15-0010841		
Date Assigned:	01/28/2015	Date of Injury:	04/01/2004
Decision Date:	03/18/2015	UR Denial Date:	01/12/2015
Priority:	Standard	Application Received:	01/20/2015

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: New Jersey, New York
 Certification(s)/Specialty: Family Practice

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 sustained an industrial injury on 4/1/2004. She has reported neck pain, left upper extremity pain and thoracic pain. The diagnoses have included thoracic outlet syndrome, myalgia and myositis, cervical syndrome, cervical spondylosis and headache. Treatment to date has included medications, diagnostics and surgery. Currently, the injured worker complains of left posterior thoracic pain, left upper extremity pain, neck pain and headaches. There was diffuse neuropathic pain and she was doing much worse at this time with increased pain with burning neuropathic symptoms. She continues with intermittent spasticity with the left arm shaking. Physical exam revealed decreased range of motion throughout left upper quadrant chest. There was diffuse allodynia in the posterior thorax over the shoulder. There is extreme left tenderness to palpation over the trapezius and infrascapular. There was pain to light touch over the left thorax. The urine drug screen was consistent with medications. Treatment plan was to continue medications and 3 more Botox injections. On /12/15 Utilization Review modified a request for Gabapentin 300mg #180 x1 refill, Fentanyl 50mcg patch #30, and Oxycodone 15mg #120 modified to Gabapentin 300mg #180 with no refill, Fentanyl 50mcg patch #15 and Oxycodone 15mg #60, noting regarding the Gabapentin partial certification is recommended to allow opportunity for submission of medication compliance guidelines including ongoing efficacy or evidence of objective functional improvement with prior use. Regarding the Fentanyl there was no documentation of objective functional improvement with prior use and regarding the Oxycodone documentation is lacking (MTUS) Medical Treatment

Utilization Schedule guidelines compliance. The (MTUS) Medical Treatment Utilization Schedule guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 300mg #180 x1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anticonvulsants, Gabapentin Page(s): 16-19, 49.

Decision rationale: The request for gabapentin is not medically necessary. According to MTUS guidelines, it is effective for diabetic painful neuropathy and postherpetic neuralgia. There should be documentation of pain relief, improvement in function, and side effects experienced by the patient. The patient had neuropathic pain but improvement in function and side effects were not documented. Guidelines recommend switching to another first-line drug if there was inadequate pain control. There is not enough documentation to support enough benefit of gabapentin for continued use. The request is considered not medically necessary.

Fentanyl 50mcg patch #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic, fentanyl, opioids Page(s): 44, 47, 78-79.

Decision rationale: The request is considered not medically necessary. According to MTUS, fentanyl is a strong opioid, eighty times more potent than morphine. The transdermal patch of fentanyl is not first-line therapy and is FDA-approved for the management of chronic pain in patients requiring continuous opioid analgesia for pain that cannot be managed by other means. The 4 A's of monitoring opioids were not met with objective evidence of improvement in pain and improvement in function, urine drug screens, or drug contract. Therefore, the request is considered not medically necessary.

Oxycodone 15mg #120: Upheld

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

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

Decision rationale: The request for oxycodone is not medically necessary. The patient has been on long-term opioid use. The chart does not provide any documentation of improvement in pain and function with the use of oxycodone. There are no documented urine drug screens or drug contracts, or long-term goals for treatment. The 4 A's of ongoing monitoring were not adequately documented. The patient had continued pain and it was unclear what kind of relief oxycodone provided. Because there was no documented improvement in pain or evidence of objective functional gains with the use of oxycodone, the long-term efficacy is limited, and there is high abuse potential, the risks of oxycodone outweigh the benefits. The request is considered not medically necessary.