MAXIMUS Federal Services

Case Number:	CM15-0113203		
Date Assigned:	06/19/2015	Date of Injury:	05/27/2003
Decision Date:	07/24/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	06/11/2015

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 York
Certification(s)/Specialty: Anesthesiology

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 53 year old, female who sustained a work related injury on 5/27/03. The diagnoses have included reflex sympathetic dystrophy upper limb, cervical spondylosis without myelopathy, muscle spasm and cervical degenerative disc disease. Treatments have included oral medications, topical pain relief cream and an implanted spinal cord stimulator. In the Pain Management Reevaluation/Follow Up Visit report dated 5/12/15, the injured worker complains of increasing neck pain with the cold/damp weather on the right. She states headaches have increased to 1-2 per week. She has nausea without vomiting. She states the burning and shooting sensation in the right shoulder remains unchanged. She states her medications are working well. She states the pain relief cream works but it is not covered. Sleep quality is poor as she is only sleeping about three hours per night. Her average pain level since last visit is 7/10. She rates her mood a 6/10. She rates her functional level a 6/10. On physical examination, she continues with ongoing severe pain in her arms, right greater than left, from the ulnar to shoulder level that radiates to her hand along with neck pain with spasm. She has decreased range of motion in cervical spine and has crepitus with neck movements. The treatment plan includes prescription refills of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celebrex 200mg #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Celebrex Page(s): 30. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Anti-inflammatory medications.

Decision rationale: Celebrex (Celecoxib) is a nonsteroidal anti-inflammatory drug (NSAID) that is a COX-2 selective inhibitor, a drug that directly targets COX-2, an enzyme responsible for inflammation and pain. Unlike other NSAIDs, Celebrex does not appear to interfere with the antiplatelet activity of aspirin and is bleeding neutral when patients are being considered for surgical intervention or interventional pain procedures. Celebrex may be considered if the patient has a risk of GI complications, but not for the majority of patients. Generic NSAIDs and COX-2 inhibitors have similar efficacy and risks when used for less than 3 months. In this case, there is no documentation of the medication's pain relief effectiveness or functional improvement, as compared to functionality using a non-prescription anti-inflammatory medication. The medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

Methadone 10mg #90 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Methadone, Opioids, ongoing management, Weaning of Medications Page(s): 61, 78, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Methadone Opioids for the treatment of chronic pain Page(s): 61-62, 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Methadone.

Decision rationale: Methadone is recommended as a second-line drug for moderate to severe pain, only if the potential benefit outweighs the risk. The FDA reports that they have received reports of severe morbidity and mortality with this medication. This appears, in part, secondary to the long half-life of the drug (8-59 hours). Pain relief on the other hand, only lasts from 4-8 hours. Genetic differences appear to influence how an individual will respond to this medication. Delayed adverse effects may occur due to methadone accumulation during chronic administration. Systemic toxicity is more likely to occur in patients previously exposed to high doses of opioids. Multiple potential drug-drug interactions can occur with the use of Methadone. This drug should be reserved for use by experienced practitioners, including pain medicine or addiction specialists. Methadone is considered useful for treatment when there is evidence of tolerance to other opiate agonists or when there is evidence of intractable side effects due to opiates. In this case, there is no documentation of objective functional benefit with prior medication use. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Continue Percocet to 10/325mg #120 from 7.5/325 #120 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, ongoing management, Weaning of Medications Page(s): 78, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and the ODG, Percocet (Oxycodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested treatment with Percocet 10/325 mg is not medically necessary.

Continue Lyrica 100mg from 75mg #120 from 50mg 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs Page(s): 16-20.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica Page(s): 58.

Decision rationale: Per the MTUS, Pregabalin (Lyrica) is recommended for neuropathic pain. Lyrica is FDA approved for diabetic neuropathy and post-herpetic neuralgia and has been used effectively for the treatment of other neuropathic pain. The guidelines indicate a good to moderate response to the use of Lyrica is a 30-50% reduction in pain. In this case, there is no documentation that guidelines have been met. In addition, there is no documentation of any significant improvement in his chronic pain condition. Medical necessity for the requested medication has not been established. The requested item is not medically necessary.