

Case Number:	CM15-0049413		
Date Assigned:	03/23/2015	Date of Injury:	02/14/2005
Decision Date:	05/13/2015	UR Denial Date:	02/26/2015
Priority:	Standard	Application Received:	03/16/2015

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: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 62-year-old female who reported an injury on 02/14/2005. The mechanism of injury was a trip and fall. During the assessment on 03/04/2015, the injured worker complained of cervical spine, lumbar spine and bilateral knee pain. The physical examination of the cervical spine revealed tenderness to palpation. There was a 30-degree loss of range of motion throughout all planes. There was 5/5 throughout the upper extremities. The physical examination of the lumbar spine revealed tenderness to palpation. Flexion was 45 degrees, extension was 10 degrees and lateral bending was 20 degrees. The physical examination of the bilateral knees revealed tenderness to palpation of the patellofemoral and medial joint bilaterally. There was crepitus with range of motion bilaterally. There was a loss of full range of motion. The treatment plan was to request authorization for medication. The rationale for the request was to assist with the injured worker's pain control. The Request for Authorization form was dated 12/04/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl patch 100 mcg #15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system) Page(s): 44.

Decision rationale: The request for fentanyl patch 100 mcg #15 is not medically necessary. The California MTUS Guidelines do not recommend Duragesic as a first line therapy. The FDA approved product-labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. The clinical documentation did not indicate that the injured worker's pain could not be managed by any other means. As such, the ongoing use is not supported. Given the above, the request is not medically necessary.

Fentanyl 25 mcg/h #15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl Page(s): 47.

Decision rationale: The request for fentanyl 25 mcg/h #15 is not medically necessary. The California MTUS Guidelines state that fentanyl is an opioid analgesic with a potency 8 times higher than that of morphine and is not recommended for musculoskeletal pain. The clinical documentation did not indicate the injured worker had attempted any other analgesic prior to the use of fentanyl. There was no quantified information regarding pain relief. There was a lack of documentation regarding adverse effects and evidence of consistent results on urine drug screens to verify appropriate medication use. Additionally, the frequency was not provided. Given the above, the request is not medically necessary.

Norco 10/325 mg #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.

Decision rationale: The request for Norco 10/325 mg #180 is not medically necessary. The California MTUS Guidelines state that ongoing management of opioid use should include documentation of pain relief, functional status, side effects and appropriate medication use with the use of random drug screening to verify compliance. There was no quantified information regarding pain relief. There was a lack of documentation regarding adverse effects and evidence of consistent results on urine drug screens to verify appropriate medication use. Additionally, the frequency was not provided. Given the above, the request is not medically necessary.

Soma 350mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 29.

Decision rationale: The request for Soma 350 mg #120 is not medically necessary. The California MTUS Guidelines state that carisoprodol is not recommended, as the medication is not indicated for long-term use. The clinical documentation submitted provided evidence that the injured worker had been on this medication for an extended duration of time and there was a lack of documentation of objective functional improvement. Additionally, the frequency was not provided. As the medication is not recommended for long-term use, the ongoing use is not supported. Given the above, the request is not medically necessary.

Cymbalta 30 mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16.

Decision rationale: The request for Cymbalta 30 mg #120 is not medically necessary. The California MTUS Guidelines recommend antidepressants as a first line medication for treatment of neuropathic pain and they are recommended especially if pain is accompanied by insomnia, anxiety or depression. There should be documentation of an objective decrease in pain and objective functional improvement to include an assessment in the changes in the use of other analgesic medications, sleep quality and duration and psychological assessments. The clinical documentation provided evidence that the injured worker had been on this medication for an extended duration of time and there was a lack of objective functional improvement. Additionally, the frequency was not provided. Given the above, the request is not medically necessary.

Protonix 20 mg #30: 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 NSAIDs Page(s): 68.

Decision rationale: The request for Protonix 20 mg #30 is not medically necessary. The California MTUS Guidelines state that proton pump inhibitors are recommended for patients

who are at intermediate or high risk for gastrointestinal events. Patients with no risk factors and no cardiovascular disease do not require the use of a proton pump inhibitor. There was no documentation that the injured worker was at intermediate or high risk for gastrointestinal events. The rationale for the requested medication was not provided. Additionally, the frequency was not provided. Given the above, the request is not medically necessary.

Gabapentin 300 mg #270: 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 Antiepilepsy drugs (AEDs) Page(s): 16-19.

Decision rationale: The request for gabapentin 300 mg #270 is not medically necessary. The California MTUS Guidelines recommend antiepilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30% to 50% and objective functional improvement. The clinical documentation provided did not indicate that there were any complaints of neuropathic pain. There was no documentation with objective decrease in pain of at least 30% to 50% with the use of the medication. Additionally, the frequency was not provided. Given the above, the request is not medically necessary.