MAXIMUS Federal Services

Case Number:	CM15-0099041		
Date Assigned:	06/01/2015	Date of Injury:	05/20/1999
Decision Date:	07/08/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	05/22/2015

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 60-year-old female, who sustained an industrial injury on 5/20/1999. The mechanism of injury was not noted. The injured worker was diagnosed as having thoracic spondylosis and lumbar radiculopathy. Treatment to date has included diagnostics, durable medical equipment, and medications. Currently, the injured worker complains of bilateral back pain, rated 9/10. Functional impairment was documented as severe, interfering with most, but not all, activities of daily living. Response to medications was noted as unchanged. Review of gastrointestinal symptoms noted that she denied nausea or vomiting but was positive for depression. Current medications included MS Contin, Oxycodone, Lyrica, Meloxicam, Terocin lotion, Zanaflex, Neurontin, and Lisinopril. The medications were consistent since at least 12/2014, with pain level 6/10 at that time. Gait exam noted a status of non-ambulatory and the use of a power wheelchair. Exam of her spine noted pain with facet loading maneuvers. Bilateral straight leg raise tests were positive for pain. Adverse side effects from medications noted moderate nausea and mild vomiting. It was noted that this visit was an added urgent appointment, due to the injured worker going out of town in the near future, and a report of her medications being stolen. The treatment plan included medication refills and trial of Ondansetron. A drug monitoring profile was performed and was documented as consistent.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ondansetron 8mg, #30: 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 Official Disability Guidelines (ODG) Pain, Antiemetics.

Decision rationale: The request is not considered medically necessary. MTUS does not address the use of Ondansetron. According to ODG guidelines, ondansetron is not recommended for nausea and vomiting due to chronic opioid analgesics. This medication is used for nausea associated with chemotherapy, treating cancer pain, or post-operative pain. This patient does not have any documented complaints in the only progress included in this limited chart. She is not being treated with chemotherapy, for cancer pain, or post-operative pain. Therefore, she will not need Ondansentron and the request is considered not medically necessary.

Terocin lotion, #2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm, topical analgesics Page(s): 56-57, 111-112.

Decision rationale: The request is not medically necessary. According to MTUS guidelines, Lidoderm is not first line treatment and is only FDA approved for post-herpetic neuralgia. More research is needed to recommend it for chronic neuropathic pain other than post-herpetic neuralgia. There are also no guidelines for the use of menthol with the patient's spine, hip and shoulder complaints. Any compounded product that contains at least one drug that is not recommended is not recommended. Topical analgesics are used when patient is unable to tolerate oral medications, which is not documented in the chart provided. Therefore, the request is considered not medically necessary.

Lyrica 75mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Specific Anti-Epilepsy Drugs Page(s): 18.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): pp19-20.

Decision rationale: The request is considered not medically necessary. Lyrica is FDA approved for the treatment of diabetic neuropathy, post-herpetic neuralgia, and fibromyalgia. The patient was not diagnosed with any of these conditions. The patient did not have objective

documentation of improvement in pain or functional capacity on this medication. Therefore, the request is considered not medically necessary.

Oxycodone 15mg, #120: Upheld

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

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, taking oxycodone for chronic back pain. The chart does not provide any objective documentation of improvement in pain and function with the use of oxycodone. There are no recent documented urine drug screens (last one from 2/2015 which was consistent) or drug contracts, or long-term goals for treatment. The 4 A's of ongoing monitoring were not adequately documented. Because there was no documented evidence of objective functional gains with the use of oxycodone, the long-term efficacy for chronic back pain is limited, and there is high abuse potential, the risks of oxycodone outweigh the benefits. The request is considered not medically necessary.

MS Contin 30mg, #90: Upheld

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

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

Decision rationale: There is not enough documentation to state MS Contin is medically necessary. There was no recently documented urine drug screens (last one was from 2/2015), drug contract, or long-term goals for treatment. The patient had continued pain and it was unclear what kind of relief MS Contin provided for the chronic back pain. It was unclear at which dose the patient was started and if the lowest possible dose was prescribed to improve pain and function. Functional improvement was not documented. The 4 A's of opioid monitoring were not documented adequately. Because there was no improvement in pain or function with the use of MS Contin, and long-term efficacy for chronic back pain is limited, and there is high abuse potential, MS Contin is considered not medically necessary at this time.