

Case Number:	CM13-0053452		
Date Assigned:	12/30/2013	Date of Injury:	05/27/2010
Decision Date:	08/18/2015	UR Denial Date:	11/18/2013
Priority:	Standard	Application Received:	11/19/2013

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 48 year old male who sustained an industrial injury on May 27, 2010. He has reported low back pain, bilateral leg pain, neck pain, bilateral arm pain, and headaches and has been diagnosed with cervical radiculopathy status post cervical spine surgery, neck pain, lumbar radiculopathy status post lumbar spine fusion, cephalgia, chronic pain syndrome, tension headaches, myofascial syndrome, and neuropathic pain. The injured workers pain score was a 9/10 at the exam and average 9/10 over the preceding week. Vital signs were stable. Activities of daily living scores were a 9/10 for sleep, 8/10 for general activity and normal walking ability, 10/10 for normal work, relations with other people, mood, and enjoyment of life. The treatment request included medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dilaudid 8mg QTY:180.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): s 76-77, 78, 80, and 86.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 44, 47, 75-79, and 120.

Decision rationale: Regarding the request for Dilaudid, California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS) and no discussion regarding aberrant use. It is also noted that the patient has inconsistent UDS results. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Dilaudid is not medically necessary.

Compound ointment (Capsaicin/Ketoprofen/Baclofen) 240gm: Upheld

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

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

Decision rationale: Regarding the request for compound ointment, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical NSAIDs are indicated for Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment, and are recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain is not recommended as there is no evidence to support use. Topical Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Baclofen is not supported by the CA MTUS for topical use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested compound ointment is not medically necessary.

Duragesic 50mg, QTY: 10.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): s 76-77, 78, 80, and 86.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 44, 47, 75-79, and 120.

Decision rationale: Regarding the request for Duragesic, California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS) and no discussion regarding aberrant use. It is also noted that the patient has inconsistent UDS results. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Duragesic is not medically necessary.

Prozac 20mg, QTY: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): s 13-15.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): s 395-6, and 402.

Decision rationale: Regarding the request for Prozac, Chronic Pain Medical Treatment Guidelines state that selective serotonin reuptake inhibitors may have a role in treating secondary depression. Additionally, guidelines recommend follow-up evaluation with mental status examinations to identify whether depression is still present. Guidelines indicate that a lack of response to antidepressant medications may indicate other underlying issues. Within the documentation available for review, there is no evidence of any recent mental status examinations identifying ongoing depression. Additionally, there is no documentation of the patient's response to the current treatment. Antidepressants should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In the absence of clarity regarding those issues, the currently requested Prozac is not medically necessary.