

Case Number:	CM13-0065838		
Date Assigned:	01/03/2014	Date of Injury:	07/17/2008
Decision Date:	04/22/2014	UR Denial Date:	12/04/2013
Priority:	Standard	Application Received:	12/13/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 52-year-old male who sustained an injury on 07/17/2008 of unspecified nature. The patient was evaluated on 11/14/2013 for right lower neck pain radiating into the right shoulder, right bicep, right forearm, and right hand with numbness and paresthesia of the right ulnar hand. The patient's medications were noted as Norco 10/325 mg every 5 hours as needed for pain, Prozac 10 mg twice a day, Pepcid 40 mg 3 times a day, Hytrin 2 mg 3 times a day, Lantus 42 units twice a day, Neurontin 300 mg 3 times a day, Fiorinal 1 to 2 tablets every 4 hours, Wellbutrin, and nortriptyline. Upon physical examination the patient was noted to have tenderness upon palpation of the left cervical paraspinal muscles overlying the C2 through C5 facet joints. The documentation indicates the patient's right shoulder and cervical facet joint provocative maneuvers were positive and the patient had decreased range of motion to the right shoulder and cervical spine secondary to pain. The treatment plan indicated the use of gabapentin 300 mg 1 tablet 3 times a day and hydrocodone 10/325 one tablet every 5 hours as needed for pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE PRESCRIPTION OF GABAPENTIN 300 MG #90 WITH 1 REFILL: Upheld

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

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

Decision rationale: The request for 1 prescription of gabapentin 300 mg #90 with refill between 11/14/2013 and 11/14/2013 is non-certified. The documentation submitted for review did not indicate the patient's pain level upon assessment. The California MTUS Guidelines state that gabapentin can be used for first line treatment of neuropathic pain. The documentation submitted for review did not indicate the patient had signs or symptoms consistent with neuropathic pain. The documentation further indicated the patient was previously taking the medication and did not indicate the patient's analgesic effect with the use of the medication. Therefore, the continued use of the medication is not supported. Given the information submitted for review the request for 1 prescription of gabapentin 300 mg #90 with refill between 11/14/2013 and 11/14/2013 is non-certified

ONE PRESCRIPTION OF HYDROCODONE 10/325 MG #150 WITH 1 REFILL:

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 Section Page(s): 78-79.

Decision rationale: The request for one prescription of hydrocodone 10/325 mg #150 with 1 refill between 11/14/2013 and 11/14/2013 is non-certified. The documentation submitted for review did not indicate the patient's pain level using the VAS pain scale or another numerical scale. The documentation submitted for review indicated the patient had previously been taking the medication but did not indicate the analgesics effect of the medication. The California MTUS Guidelines recommend ongoing monitoring of opioid therapy to include pain relief, side effects, physical and psychosocial functioning and the occurrence of any aberrant or non-adherent drug related behaviors. The documentation submitted for review did not indicate the patient's pain level with the medications and without the medications to clarify efficacy. Furthermore, the documentation submitted for review did not indicate the patient had any functional improvement with the continued use of the medication. The California MTUS Guidelines recommend discontinuation of opioids if there is no overall improvement and functional ability, unless there are extenuating circumstances. The documentation submitted for review did not indicate the patient had extenuating circumstances to continue the use of the medication. Therefore, the continued use of the medication is not supported. Given the information submitted for review the request for one prescription of hydrocodone 10/325 mg #150 with 1 refill between 11/14/2013 and 11/14/2013 is non-certified