

<b>Case Number:</b>	CM14-0003543		
<b>Date Assigned:</b>	01/31/2014	<b>Date of Injury:</b>	02/18/2011
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	12/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2014

### 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 is licensed to practice in Texas. 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 injured worker is a 54-year-old female who reported an injury on 02/18/2011 when a tree fell on the injured worker. The injured worker's diagnoses included post traumatic stress disorder, shoulder derangement, shoulder pain, pelvic pain, lower leg pain, plantar fibromatosis, and status post hip joint replacement. The injured worker's treatment history included physical therapy, multiple medications, and psychiatric support. The injured worker was evaluated on 12/09/2013. It was documented that the injured worker's medications included B12, folic acid, gabapentin, hydrocodone, Lidoderm patches, lorazepam, and tramadol. It was noted within the documentation that the injured worker's pain levels remained high. Medications were used several times a day. Physical findings included assisted ambulation with a cane with a slow and steady gait, restricted range of motion of the hip secondary to pain and restricted range of motion of the right shoulder secondary to pain with tenderness to palpation over the acromioclavicular joint. The injured worker's diagnoses included hip pain, knee pain, shoulder pain. The injured worker's treatment plan included continued medication usage.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NORCO (HYDROCODONE/ACETAMINOPHEN) 10/325 MG #240 WITH THREE REFILLS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS, 77, 78

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

**Decision rationale:** The requested hydrocodone/acetaminophen 10/325 mg #240 with 3 refills is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for over a year. California Medical Treatment Utilization Schedule recommends continued use of opioids in the management of chronic pain be supported by ongoing documentation of functional benefit, evidence of pain relief, managed side effects, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review fails to provide any functional benefit as a result of the prescribed medication. Additionally, there is no quantitative assessment to support pain relief. There is no documentation that the injured worker is monitored for aberrant behavior. The request as it is submitted does not clearly identify a frequency of treatment. Furthermore, the request is for 3 refills. This does not allow for ongoing assessment to establish efficacy. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested Norco (hydrocodone/acetaminophen) 10/325 mg #240 is not medically necessary or appropriate.

**NEURONTIN (GABAPENTIN) 300 MG #120 WITH THREE REFILLS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ANTIEPILEPTIC MEDICATIONS, 18

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Anti-Epileptics Page(s): 60, 16.

**Decision rationale:** The requested Neurontin (gabapentin) 300 mg #120 with 3 refills is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for at least a year. California Medical Treatment Utilization Schedule recommends anticonvulsants as a first line medication in the management of chronic pain; however, California Medical Treatment Utilization Schedule recommends ongoing use of medications be supported by functional benefit and pain relief. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's pain to support that there is any pain relief related to medication usage. There is no documentation of functional benefit relating to medication usage. Additionally, the request is for 3 refills. This does not allow for timely reassessment and evaluation of efficacy of the requested medication. Furthermore, the request as it is submitted does not clearly identify a frequency. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Neurontin (gabapentin) 300 mg #120 with 3 refills is not medically necessary or appropriate.

