

Case Number:	CM14-0106602		
Date Assigned:	07/30/2014	Date of Injury:	08/08/2005
Decision Date:	09/09/2014	UR Denial Date:	06/18/2014
Priority:	Standard	Application Received:	07/09/2014

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 Rehabilitation & Pain Management has a subspecialty in Interventional Spine and is licensed to practice in California. 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 61 year old with an injury date on 8/8/05. Patient complains of severe, worsening low lumbar pain with radiation into left lower extremity, left lateral hip pain, severe cervicospinal pain with spasm into left upper extremity, and severe left shoulder pain per 5/28/14 report. Patient has frequent falls with poor balance per 5/28/14 report. Based on the 5/28/14 progress report provided by [REDACTED] the diagnoses are: 1. severe lower back pain due to symptomatic lumbar spinal stenosis and spinal instability at L5-S1; 2. chronic cervical pain due to diffuse degenerative disc disease leading to cervical spinal stenosis; 3. left shoulder pain due to severe shoulder impingement, degenerative arthritis and adhesive capsulitis; 4. left hip pain due to osteoarthritis and greater trochanteric bursitis; 5. difficulty walking, multifactorial; 6. diabetic peripheral polyneuropathy. Exam on 5/28/14 showed "antalgic gait pattern favoring left lower extremity, using single-point cane to ambulate. L-spine range of motion extremely limited in extension to neutral. Positive straight leg raise on left at 35-40 degrees. Bilateral hips: restricted range of motion. Cervical exam showed muscle spasm and left torticollis. Severe impingement on left shoulder. Deep tendon reflexes are hyperreflexic. Decreased pinprick in left C5-C8 dermatome. Decreased sensation in left L4-S1 dermatome." [REDACTED] is requesting Gralise 600mg #30 3 refills and Norco 10/325mg #120 3 refills. The utilization review determination being challenged is dated 6/18/14. [REDACTED] is the requesting provider, and he provided treatment reports from 2/5/13 to 5/28/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gralise 600mg #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Gralise) Antiepilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs); Neurontin Page(s): 16-18; 18-19 and on the Non-MTUS Citation ODG-TWC guidelines, Knee chapter for Restless legs syndrome (RLS).

Decision rationale: This patient presents with lower back pain radiating to left lower extremity, left left neck pain left shoulder pain, and left hip pain. The treating physician has asked for Gralise 600mg #30 3 refills on 5/28/14. Patient was given a sample of Gralise on 8/1/13 with no explanation. As of 5/28/14, patient is still on a "sample" of Gralise. Gralise is a long-acting gabapentin and MTUS supports the use of this medication for neuropathic pain. MTUS requires that at least 30% reduction of pain demonstrated with use of this medication. In this case, the patient has been on this medication for 7 months and the treating physician does not explain medication efficacy. There are no discussions that this medication has done anything for this patient. Therefore, the request is not medically necessary.

Norco 10/325mg #120 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78.

Decision rationale: This patient presents with lower back pain radiating to left lower extremity, left left neck pain left shoulder pain, and left hip pain. The treating physician has asked for Norco 10/325mg #120 3 refills on 5/28/14. Patient began taking opiates on 6/21/10 when he began Vicodin. On 12/4/12, patient switched to Norco per 3/3/13 report and is currently still on Norco. The 5/28/14 report states "Norco 3 to 4 pills per day, not helping." For chronic opioids use, MTUS guidelines require specific documentation regarding pain and function, including: least reported pain over period since last assessment; average pain; intensity of pain after taking opioid; how long it takes for pain relief; how long pain relief lasts. Furthermore, MTUS requires the 4 A's for ongoing monitoring including analgesia, ADL's, adverse side affects, and aberrant drug-seeking behavior. Review of the included reports do not discuss opiates management. There are no discussions of the four A's and no discussion regarding pain and function related to the use of Norco. Given the lack of sufficient documentation regarding chronic opiates management as required by MTUS, therefore, the request is not medically necessary.