

<b>Case Number:</b>	CM14-0109750		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	02/07/2005
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	07/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2014

### 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 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 injured worker is a 59-year-old male who reported an injury on 02/07/2005. The mechanism of injury was not specifically stated. Current diagnoses include status post L3-4 discectomy on 07/18/2005, status post L2-4 laminectomy/discectomy on 03/05/2013, mild chronic denervation with radiculopathy, bilateral shoulder pain, depression, insomnia, and abnormal renal function testing. The injured worker was evaluated on 04/14/2014. It is noted that the injured worker was recently issued authorization for a right shoulder arthroscopic rotator cuff repair. The injured worker presented with complaints of lower back pain with numbness in the lower extremities and right shoulder pain. Previous conservative treatment includes medication management and postoperative physical therapy for the lumbar spine. The current medication regimen includes Percocet 10/325 mg, gabapentin 600 mg, Cymbalta 30 mg, dalmane 30 mg, Protonix 40 mg, and Laxacin. Physical examination on that date revealed moderate bilateral paraspinous tenderness, 1+ muscle spasm, diminished strength in the right lower extremity, hypesthesia in the right L4 and L5 dermatomes, and diminished reflexes in the lower extremities. Treatment recommendations at that time included continuation of the current medication regimen. There was no DWC Form RFA submitted on the requesting date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 600mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-19.

**Decision rationale:** California MTUS Guidelines state gabapentin is recommended for neuropathic pain. The injured worker has utilized this medication since 09/2013. Although the injured worker reports an improvement in symptoms, there is no evidence of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Cymbalta 30mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

**Decision rationale:** California MTUS Guidelines state Cymbalta has been FDA approved for anxiety, depression, diabetic neuropathy, fibromyalgia, neuropathic pain, and radiculopathy. The injured worker has utilized this medication since 09/2013. Although the injured worker reported an improvement in symptoms, there is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Laxacin #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 70. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain chapter, Opioid Induced Constipation Treatment.

**Decision rationale:** California MTUS Guidelines state prophylactic treatment of constipation should be initiated when also initiating opioid therapy. The Official Disability Guidelines state first line treatment for opioid induced constipation includes increasing physical activity, maintaining appropriate hydration, and advising the patient to follow a proper diet. There is no documentation of a failure to respond to first line treatment. There is also no strength or frequency listed in the request. As such, the request is not medically necessary.

**Trazodone 100mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Trazodone.

**Decision rationale:** California MTUS Guidelines recommend antidepressants as a first line option for neuropathic and as a possibly for non-neuropathic pain. The Official Disability Guidelines recommend trazodone for insomnia, only for patients with potentially coexisting mild psychiatric symptoms, such as depression or anxiety. The injured worker does not present with symptoms of depression or anxiety. There is also no documentation of a failure to respond to nonpharmacologic treatment for insomnia prior to the initiation of a prescription product. There is also no frequency listed in the request. As such, the request is not medically necessary.

**Trial Diclofenac 100mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 67-72.

**Decision rationale:** California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. There is no documentation of an acute exacerbation of chronic pain. Guidelines do not recommend long term use of NSAIDs. There was no frequency listed in the request. As such, the request is not medically necessary.

**Percocet 10/325 #100:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state that a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized this medication since 09/2013. Although the injured worker reported an improvement in symptoms, there is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.