

<b>Case Number:</b>	CM14-0022566		
<b>Date Assigned:</b>	05/07/2014	<b>Date of Injury:</b>	08/02/2005
<b>Decision Date:</b>	07/09/2014	<b>UR Denial Date:</b>	01/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/21/2014

### 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 and 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:

This 55 year-old patient sustained an injury on 8/2/05. Requests under consideration include GRALISE STARTER PACK #1, REGLAN 10MG, #90, and AMITRIPTYLINE 50MG, #30 + 3 REFILLS. Diagnoses include Myofascial pain/myostis; lumbar spine neuritis/radiculitis s/p lumbar laminectomy syndrome ; sciatica; and chronic pain syndrome. Report of 1/7/14 from the provider noted the patient with complaints of increased pain in entire back radiating up neck and down legs and arms rated at 8/10. Medications list Terocin lotion, Colace, Omeprazole, Norco, Amitriptyline, Butrans patch, Zofran, Oxycodone, Reglan, and Oxycodone. Exam showed limited range in the lumbar spine in all planes, diffuse weakness in lower extremities bilaterally in all myotomes, decreased sensation throughout bilateral left hand and calf with 2+ patellar and 3+ achilles tendon reflexes. Medications were refilled with requests above. Report of 2/5/14 and 3/5/14 had unchanged symptoms complaints and clinical findings with treatment plan for refilling medications. The requests for the above medications of Gralise and Reglan were non-certified and Amitriptyline was partially-certified without refills on 1/24/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**GRALISE STARTER PACK #1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-EPILEPSY DRUGS (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-EPILEPSY DRUGS/GABAPENTIN Page(s): 18-19.

**Decision rationale:** Gralise has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain; however, submitted reports have not adequately demonstrated the specific indication to support for Gralise without clinical findings of neurological deficits or neuropathic pain. Previous treatment with Gralise per subsequent reports has not resulted in any functional benefit with unchanged chronic symptom complaints and diffuse clinical findings with continued medication refills. The gralise starter pack #1 is not medically necessary and appropriate.

**REGLAN 10MG, #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines I SYMPTOMS AND CARDIOVASCULAR RISK Page(s): 68-69.

**Decision rationale:** Metoclopramide HCl (Reglan) is a gastrointestinal stimulant used to treat gastroesophageal reflux/erosions/ulcers of the esophagus and diabetic gastroparesis. Per MTUS Chronic Pain Treatment Guidelines, the patient does not meet criteria to support for medication use namely reserved for patients with history of prior GI bleeding, the elderly (over 65 years), diabetics, and chronic cigarette smokers. Submitted reports have not described or provided any GI diagnosis that meets the criteria to indicate medical treatment. Review of the records show no documentation of any history, symptoms, or GI diagnosis to warrant this medication. The Reglan 10MG, #90 is not medically necessary and appropriate.

**AMITRIPTYLINE 50MG, #30 + 3 REFILLS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS FOR CHRONIC PAIN.

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

**Decision rationale:** Per Guidelines, Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment; however, submitted reports have not demonstrated the medical indication or functional improvement from treatment already rendered for this 2005 injury with chronic pain complaints. Report has noted the patient with complaints of persistent pain taking chronic opiates without

improvement. The Amitriptyline 50mg, #30 + 3 refills is not medically necessary and appropriate.