

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0026004 | | |
| Date Assigned: | 06/13/2014 | Date of Injury: | 11/08/2004 |
| Decision Date: | 07/24/2014 | UR Denial Date: | 02/26/2014 |
| Priority: | Standard | Application Received: | 02/28/2014 |

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 Pain Medicine 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 51-year-old female who reported an injury on 11/08/2004. The mechanism of injury was not specifically stated. Current diagnoses include lumbar disc disorder, lumbar facet syndrome, lumbar radiculopathy, shoulder pain, carpal tunnel syndrome, pain in a joint of the lower leg, knee pain, cervical pain, cervical radiculopathy, and low back pain. The injured worker was evaluated on 06/05/2014 with complaints of 5/10 pain. Current medications include Motrin 800 mg, Trazodone 50 mg, Voltaren 1% gel, MS-Contin 15 mg, Neurontin 600 mg, Norco 10/325 mg, and Soma 350 mg. Physical examination revealed restricted cervical range of motion, spasm, tenderness, tightness, positive Spurling's maneuver, restricted lumbar range of motion, paravertebral muscle tenderness with tightness, positive facet loading maneuver, positive straight leg raising on the right, tenderness in the rhomboids and trapezius muscles, mild swelling in the right knee, restricted knee range of motion, diminished strength in the lower extremities and decreased sensation. Treatment recommendations at that time included continuation of current medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

NEURONTIN 600MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

Decision rationale: California MTUS Guidelines state antiepilepsy drugs are recommended for neuropathic pain. The injured worker has utilized Neurontin 600 mg since 08/2012. Despite ongoing use of this medication, the injured worker continues to report persistent pain. There is no documentation of objective functional improvement that would warrant the need for ongoing use of this medication. There is also no frequency listed in the current request. As such, the request is non-certified.

VOLTAREN GEL 1% #3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state the only FDA approved topical NSAID is Diclofenac or Voltaren gel 1%. Voltaren gel is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment. It has not been evaluated for treatment of the spine, hip, or shoulder. Therefore, the current request is not medically appropriate. There is also no frequency listed in the current request. As such, the request is non-certified.

TRAZODONE 50MG X 1 MONTH SUPPLY: Upheld

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

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 (Desyrel).

Decision rationale: California MTUS Guidelines state antidepressants are recommended as a first line option for neuropathic pain and as a possibility for non-neuropathic pain. Official Disability Guidelines state Trazodone is recommended as an option for insomnia, only for patients with potentially co-existing mild psychiatric symptoms such as depression or anxiety. The injured worker does not maintain diagnoses of chronic insomnia, depression, or anxiety. Therefore, the current request is not medically appropriate. There is also no frequency listed in the current request. As such, the request is non-certified.

NORCO 10/325MG #60: Upheld

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

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

Decision rationale: California MTUS Guidelines state 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 08/2012. There is no evidence of objective functional improvement. There is also no frequency listed in the current request. As such, the request is non-certified.

SOMA 350MG #20: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. Soma should not be used for longer than 2 to 3 weeks. The injured worker has utilized this medication since 08/2012, without any evidence of objective functional improvement. The injured worker continues to demonstrate palpable muscle spasms. There is also no frequency listed in the current request. Therefore, the request is non-certified.

MS CONTIN 15MG #60: Upheld

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

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

Decision rationale: California MTUS Guidelines state 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 12/2013. There is no evidence of objective functional improvement. There is also no frequency listed in the current request. As such, the request is non-certified.