

Case Number:	CM14-0060841		
Date Assigned:	07/09/2014	Date of Injury:	09/12/2005
Decision Date:	09/09/2014	UR Denial Date:	04/21/2014
Priority:	Standard	Application Received:	05/01/2014

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 Occupational Medicine, 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 is a 56-year-old female patient with a 9/12/05 date of injury. A progress report dated on 5/5/14 indicated that the patient rated his pain 4/10 with medication and 9/10 without medication. His activity level was the same. She complained of lower back and right shoulder pain. Her quality of sleep was fair. Objective findings revealed restricted range of motion on the lumbar spine with extension. There was tenderness on the paravertebral muscles. The patient had bilateral trigger point with pain radiation and twitch response on palpitation at the paraspinal muscles. There was limited range of motion over the right shoulder. She was diagnosed with Lumbar spine degenerative disc disease, Lumbar postlaminectomy syndrome, and Shoulder joint pain. Treatment to date: medication management. There is documentation of a previous 4/24/14 adverse determination. Gabapentin was not certified, based on the fact that there was no documentation of neuropathic pain. Trazodone was modified from 5 refills to 1 refill, and Amitza was not certified, based on the fact that there was no documentation of failure of conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin (Neurontin) 300mg #180 refill x5: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines; chronic pain chapter revised 8/8/08 page 110.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Anti-epileptic drugs pages 16-18, Gabapentin) Page(s): 49.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines states that Gabapentin has been shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The patient presented with pain in his lower back. Objective findings revealed trigger points with pain radiation and twitch response on palpitation at the paraspinal muscle over the lumbar spine. On 4/30/14, the patient is noted to have neuropathic pain and has a diagnosis of post-laminectomy syndrome. Guidelines recommend Gabapentin as a first-line treatment for neuropathic pain. Therefore the request for Gabapentin (Neurontin) 300mg #180 refill x5 was medically necessary.

Trazadone 50mg q hs #60 refill x5: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Pain Chapter; Anti-depressants.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter Trazodone.

Decision rationale: CA MTUS does not address this issue. ODG recommends Trazodone as an option for insomnia only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. Trazodone has also been used successfully in fibromyalgia. The patient presented with the pain in his lower back. However, it was noted that the patient's sleep quality was fair. It was noted that Trazodone is helping with sleep and neuropathic-type pain at night. However, this request is for 60 tablets with 5 refills, which would equal a year supply, which is excessive. The UR decision modified the trazodone from 5 refills to 1 refill. Therefore, the request for Trazadone 50mg qhs #60 refill x5, as submitted, was not medically necessary.

Amitiza 8mcg cap #30 refill x5: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/history/ Amitiza.html> Amitiza.

Decision rationale: CA MTUS and ODG do not address this issue. Amitiza (lubiprostone) is a selective chloride channel activator for the treatment of chronic idiopathic constipation and opioid-induced constipation in adults, and irritable bowel syndrome with constipation in adult women. However, there was no documentation of constipation or irritable bowel syndrome. In

addition, there was no evidence of previous medication management of constipation. Therefore, the request for Amitiza 8mcg cap #30 refill x5 was not medically necessary.