

Case Number:	CM14-0204975		
Date Assigned:	12/17/2014	Date of Injury:	08/16/1991
Decision Date:	02/06/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	12/08/2014

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:

According to the records made available for review, this is a 78-year-old male with an 8/16/91 date of injury. At the time (11/13/14) of the Decision for authorization for 180 Capsules of Neurontin 100mg, 1 Voltaren gel 1%, 120 Tablets of Ultram 50mg, and 120 Tablets of Seroquel 50mg, there is documentation of subjective (pain located in the lower back, foot, knee, shoulder and neck described as aching, sharp, stabbing and with tenderness, pain radiates to bilateral legs, and is rated 10/10 without medications and 5/10 with pain medications) and objective (lumbar spine range of motion abnormal at 45 degrees of flexion, 10 degrees of extension, 15 degrees of right and left lateral flexion, and 10 degrees of right and left rotation, pain with lumbar spine range of motion testing, Patrick test and Revers Thomas test positive bilaterally, and tenderness to palpation over the lumbar facet joints) findings, current diagnoses (lumbosacral spondylosis without myelopathy, disorder of bursae and tendons in shoulder region, congenital spondylosis of the lumbosacral region, cervical spondylosis without myelopathy, disorder of rotator cuff syndrome of shoulder and allied disorders, adhesive capsulitis of shoulder, thoracic or lumbosacral neuritis or radiculitis, and degeneration of lumbar or lumbosacral intervertebral disc), and treatment to date (medications (including ongoing treatment with Ultram, Neurontin, and Voltaren gel since at least 8/1/14), physical therapy, and trigger point injections). Medical report identifies Seroquel is new for a trial. In addition, medical reports identify the patient signed a pain agreement. Regarding 180 Capsules of Neurontin 100mg, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Neurontin use to date. Regarding 1 Voltaren gel 1%, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment, short-term use, failure of an oral NSAID or contraindications to oral NSAIDs, and functional benefit or improvement as a reduction in

work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Voltaren gel use to date. Regarding 120 Tablets of Ultram 50mg, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ultram use to date. Regarding 120 Tablets of Seroquel 50mg, there is no documentation of Seroquel used as a second line therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

180 Capsules of Neurontin 100mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (Gabapentin). MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbosacral spondylosis without myelopathy, disorder of bursae and tendons in shoulder region, congenital spondylosis of the lumbosacral region, cervical spondylosis without myelopathy, disorder of rotator cuff syndrome of shoulder and allied disorders, adhesive capsulitis of shoulder, thoracic or lumbosacral neuritis or radiculitis, and degeneration of lumbar or lumbosacral intervertebral disc. In addition, there is documentation of ongoing treatment with Neurontin and neuropathic pain. However, despite documentation of 10/10 pain without medications and 5/10 with pain medications, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Neurontin use to date. Therefore, based on guidelines and a review of the evidence, the request for 180 Capsules of Neurontin 100mg is not medically necessary.

1 Voltaren gel 1%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Diclofenac sodium; Other Medical

Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to support the medical necessity of Diclofenac Sodium 1%. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of failure of an oral NSAID or contraindications to oral NSAIDs and used as second line treatment, as criteria necessary to support the medical necessity of Diclofenac Sodium gel. Within the medical information available for review, there is documentation of diagnoses of lumbosacral spondylosis without myelopathy, disorder of bursae and tendons in shoulder region, congenital spondylosis of the lumbosacral region, cervical spondylosis without myelopathy, disorder of rotator cuff syndrome of shoulder and allied disorders, adhesive capsulitis of shoulder, thoracic or lumbosacral neuritis or radiculitis, and degeneration of lumbar or lumbosacral intervertebral disc. In addition, there is documentation of Voltaren gel used as second line treatment. However, despite documentation of subjective (pain located in the foot and knee) findings, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). In addition, given documentation of ongoing treatment with Voltaren gel since at least 8/1/14, there is no documentation of short-term use (4-12 weeks). Furthermore, there is no documentation of failure of an oral NSAID or contraindications to oral NSAIDs. Lastly, despite documentation of 10/10 pain without medications and 5/10 with pain medications, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Voltaren gel use to date. Therefore, based on guidelines and a review of the evidence, the request for 1 Voltaren gel 1% is not medically necessary.

120 Tablets of Ultram 50mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80;113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; as criteria necessary to support the medical necessity of Opioids. In addition, specifically regarding Tramadol, MTUS Chronic Pain Medical Treatment Guideline identifies documentation of moderate to severe pain and Tramadol used as a second-line treatment (alone or in combination with first-line drugs), as criteria necessary to support the medical necessity of Tramadol. Within the medical information

available for review, there is documentation of diagnoses of lumbosacral spondylosis without myelopathy, disorder of bursae and tendons in shoulder region, congenital spondylosis of the lumbosacral region, cervical spondylosis without myelopathy, disorder of rotator cuff syndrome of shoulder and allied disorders, adhesive capsulitis of shoulder, thoracic or lumbosacral neuritis or radiculitis, and degeneration of lumbar or lumbosacral intervertebral disc. In addition, there is documentation of ongoing treatment with Ultram and Ultram used as a second-line treatment. Furthermore, given documentation of a pain agreement, there is documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, despite documentation of 10/10 pain without medications and 5/10 with pain medications, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ultram use to date. Therefore, based on guidelines and a review of the evidence, the request for 120 tablets of Ultram 50mg is not medically necessary.

120 Tablets of Seroquel 50mg: 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), Mental, Quetiapine (Seroquel)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter AND Pain Chapter, Antidepressants AND Seroquel; Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain, as criteria necessary to support the medical necessity of antidepressants. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of depression, as criteria necessary to support the medical necessity of antidepressants. In addition, ODG identifies that Seroquel is not recommended as a first line treatment. Within the medical information available for review, there is documentation of diagnoses of lumbosacral spondylosis without myelopathy, disorder of bursae and tendons in shoulder region, congenital spondylosis of the lumbosacral region, cervical spondylosis without myelopathy, disorder of rotator cuff syndrome of shoulder and allied disorders, adhesive capsulitis of shoulder, thoracic or lumbosacral neuritis or radiculitis, and degeneration of lumbar or lumbosacral intervertebral disc. In addition, there is documentation of chronic pain and a plan to trial Seroquel. However, there is no documentation of Seroquel used as a second line therapy. Therefore, based on guidelines and a review of the evidence, the request for 120 tablets of Seroquel 50mg is not medically necessary.