

Case Number:	CM15-0004939		
Date Assigned:	01/16/2015	Date of Injury:	01/13/2010
Decision Date:	04/01/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/09/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Pediatrics, Internal Medicine

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 36-year-old female, who sustained an industrial injury on 01/13/2010. Medical records provided did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed with myofascial sprain and strain of the cervical and thoracic spine with intermittent low back pain, shoulder tendinitis, and anxiety and depression. Treatment to date has included a home exercise program, use of ice packs, acupuncture, and a medication history of Nucynta, Nortriptyline, Gabapentin, Celebrex, Butrans patch, Dilaudid, Celebrex, and Zohydro. Currently, the injured worker complains of pain to the neck and upper back that radiates to the upper extremity with a rating of ten on a scale of one to ten. The documentation provided did not contain the reason for the requested prescriptions for Nortriptyline, Neurontin, Ibuprofen, and Zohydro ER. On 12/23/2014, Utilization Review non-certified the prescriptions of Nortriptyline 25 mg, sixty count; Neurontin 600 mg, sixty count; Ibuprofen 800 mg, 100 count; and Zohydro ER 20 mg, sixty count, noting the California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, pages 17-18 and pages 68-69.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nortriptyline 25 mg, sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Tricyclic antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. 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. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. There was no notation in the documentation of benefit from the tricyclic antidepressant related to decreased use of other medications, improved mood, and improved level of function or assessment of possible side effects. As appropriate monitoring and documentation were not provided, the medication is not currently medically necessary and appropriate.

Neurontin 600 mg, sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 18.

Decision rationale: AED's are not recommended, as there is a lack of evidence to demonstrate that AEDs significantly reduce the level of myofascial or other sources of somatic pain. There is no notation in the records provided that the IW had clinical evident neuropathy related to her degenerative disc disease. The neurontin is not medically necessary at this time.

Ibuprofen 800 mg, 100 count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 17 - 18.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's Page(s): 67-68.

Decision rationale: NSAID's are recommended as a second-line treatment after acetaminophen for exacerbations of chronic back pain. There is no evidence that the IW had an adequate trial of acetaminophen. The NSAID is not medically necessary and appropriate at this time.

Zohydro ER 20 mg, sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 - 69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; CRITERIA FOR USE OF OPIOIDS; 4) On-Going Management Page(s): 78.

Decision rationale: ZOXYDRO ER (hydrocodone bitartrate) is FDA indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. However, ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects is required. The provided documentation did not include the least reported pain over the period since the last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, or how long the pain relief lasted. Therefore, the Zohydro ER is not medically necessary and appropriate at this time.