

Case Number:	CM15-0009775		
Date Assigned:	01/27/2015	Date of Injury:	07/30/2002
Decision Date:	03/24/2015	UR Denial Date:	01/06/2015
Priority:	Standard	Application Received:	01/16/2015

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: California, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 37-year-old male who reported an injury on 07/30/2002. The mechanism of injury was not provided. The diagnoses included lumbago, unspecified myalgia and myositis, other specified back disorder, displacement of the thoracic or lumbar intervertebral disc without myelopathy, postlaminectomy syndrome of the cervical and lumbar region, unspecified neuralgia, neuritis, and radiculitis, and encounter for long term medication. The injured worker was noted to utilize the requested medications since at least 10/2014. The documentation of 12/19/2014, revealed the injured worker was in the office for a refill of medications, and the injured worker indicated pain was worse with cold weather. The physical examination revealed tenderness of the lumbosacral junction, without myospasms being present. Range of motion was approximately 30 degrees in flexion and 10 degrees in extension. The diagnoses included failed back syndrome. The treatment plan included Neurontin 800 mg 1 by mouth 3 times a day #90, Percocet 10/325 mg on by mouth 4 times a day #120, methadone 10 mg 1 by mouth daily #60, and Soma 350 mg 1 by mouth twice a day #60. There was no request for authorization submitted for request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 800mg/tab, #90, refills unspecified, 1 tab orally thrice a day: 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 Antiepileptic Drugs Page(s): 16.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend antiepilepsy medications as a first line option for the treatment of neuropathic pain. There should be documentation of objective functional improvement and objective decrease in pain of at least 30% to 50%. The clinical documentation submitted for review failed to indicate the injured worker had 30% to 50% objective pain relief, and there was a lack of documentation of objective functional improvement. The request indicated that there was a request for refills, which were unspecified. This medication would not be supported. Given the above, the request for Neurontin 800 mg/tab #90, refills unspecified, 1 tablet orally thrice a day, is not medically necessary.

Percocet 10/325mg/tab #120, refills:unspecified, 1 tab orally four times a day: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain; ongoing management Page(s): 60; 78.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to indicate the injured worker was being monitored for aberrant drug behavior and side effects, and there was a lack of documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the quantity of refills being requested. Given the above, the request for Percocet 10/325 mg/tab #120, refills unspecified, 1 tab orally four times a day, is not medically necessary.

Methadone 10mg/tab, #60, Refills:unspecified, 1 tab orally daily: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain; ongoing management Page(s): 60; 78.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured

worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to indicate the injured worker was being monitored for aberrant drug behavior and side effects, and there was a lack of documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the quantity of refills being requested. Given the above, the request for Methadone 10 mg/tab #60, refills unspecified, 1 tab orally daily, is not medically necessary.

Soma 350mg/tab, #60, Refills:unspecified, 1 tab orally twice a day: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines, non-sedating muscle relaxants

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain. Their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker has utilized the medication for an extended duration of time. There was a lack of documentation of objective improvement. The request as submitted failed to indicate the quantity of refills being requested. Given the above, the request for Soma 350 mg/tab #60, refills unspecified, 1 tab orally twice a day, is not medically necessary.