MAXIMUS Federal Services

Case Number:	CM15-0102319		
Date Assigned:	06/04/2015	Date of Injury:	06/16/2010
Decision Date:	08/06/2015	UR Denial Date:	05/18/2015
Priority:	Standard	Application Received:	05/27/2015

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
Certification(s)/Specialty: Emergency 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 67 year old female patient who sustained an industrial injury on 06/16/2010. The accident was described as the patient slipped on top step of flight of stairs landing on her sacrum, coccyx, and both hands trying to stop the fall. She then reached to left hand-rail got caught flipped over doing two somersaults landing on the floor. A doctor's first report of illness dated 02/24/2015 reported the patient with subjective complaint of having low back pain and bilateral thigh and leg pain that is constant. In addition, she is with complaint of neck, upper and mid back pains and headaches. Objective findings showed lumbar range of motion very limited with pain in the lumbosacral area. There was a positive Minors, positive right straight leg raising at 45 degrees to the L4-5 across ilium. Palpation showed multiple trigger points in the thoracic, lumbar, erector spinae, quadratus lumborum, gluteus medius, minimus, and piriformis. There was also a positive Jump sign and pressure reproduces the pain. She was diagnosed with the following: chronic low back and leg pain; chronic cervical and thoracic pain due to trauma; chronic cervical, thoracic, lumbar, gluteal myofascial pain syndrome, and headaches. Treatment rendered this visit included: ultrasound, transverse friction massage, myofascial release, moist heat and therapeutic exercises. An occupational follow up dated 11/18/2014 reported chief complaint of back, shoulder pain and left lower extremity radiculopathy. She is in need of prescription refill this visit to include: Norco, Gabapentin, and Flexeril. The assessment noted the patient with left shoulder pain, chronic low back pain, and left lower extremity radiculopathy. The plan of care involved pending neurosurgical procedure; recommending a repeat magnetic resonance imaging study; maintain modified work duty, and medication refill.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg, #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-GoingManagement, Opioids for Chronic Pain Page(s): 78-82.

Decision rationale: The requested Norco 10/325 mg, #240, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has back, shoulder pain and left lower extremity radiculopathy. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, and objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above have not been met. Therefore, the request for Norco 10/325 mg, #240 is not medically necessary.

Gabapentin 300 mg #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy drugs Page(s): 16-18, 21.

Decision rationale: The requested Gabapentin 300 mg #240 is not medically necessary. Chronic Pain Medical Treatment Guidelines, Anti-Epilepsy drugs, Pages 16-18, 21, note that anti- epilepsy drugs are" Recommended for neuropathic pain due to nerve damage, and Outcome: A good response to the use of AEDs has been defined as a 50% reduction in pain and a moderate response as a 30% reduction." The injured worker has back, shoulder pain and left lower extremity radiculopathy. The treating physician has not documented the guideline-mandated criteria of percentages of relief to establish the medical necessity for its continued use. The criteria noted above have not been met. Therefore, the request for Gabapentin 300 mg #240 is not medically necessary.

Amitriptyline 25 mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13-15.

Decision rationale: The requested Amitriptyline 25 mg #30 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Antidepressants for Chronic Pain, Pages 13-15, recommend tricyclic antidepressants as a first- line agent for the treatment of chronic pain, neuropathic pain and depression, unless they are ineffective, poorly tolerated, or contraindicated. The injured worker has back, shoulder pain and left lower extremity radiculopathy. The treating physician has not documented duration of treatment, or objective evidence of derived functional improvement from its use. The criteria noted above have not been met. The request for Amitriptyline 25 mg #30 is not medically necessary.

Flexeril 10 mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

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

Decision rationale: The requested Flexeril 10 mg #90 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Muscle Relaxants, Page 63-66, do not recommend muscle relaxants as more efficacious that NSAID s and do not recommend use of muscle relaxants beyond the acute phase of treatment. The injured worker has back, shoulder pain and left lower extremity radiculopathy. The treating physician has not documented duration of treatment, spasticity or hypertonicity on exam, intolerance to NSAID treatment, or objective evidence of derived functional improvement from its previous use. The criteria noted above have not been met. Therefore, the request for Flexeril 10 mg #90 is not medically necessary.