

<b>Case Number:</b>	CM15-0105276		
<b>Date Assigned:</b>	06/09/2015	<b>Date of Injury:</b>	10/02/2013
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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 33 year old female, who sustained an industrial injury on October 2, 2013. The mechanism of injury was a trip and fall. The injured worker has been treated for neck, back and left wrist complaints. The diagnoses have included lumbar degenerative joint disease, lumbar herniated nucleus pulposus, lumbar radiculopathy, cervical sprain, cervical disc displacement and low back pain. Treatment to date has included medications, radiological studies, MRI, individual, electrodiagnostic studies, psychological treatments, psychological testing, a transcutaneous electrical nerve stimulation unit, epidural steroid injections, acupuncture treatments, a home exercise program and physical therapy. Current documentation dated April 14, 2015 notes that the injured worker reported increased low back pain with radiation to the left lower extremity to the toes. Associated symptoms included weakness, numbness and tingling. The injured worker was noted to have fallen three weeks prior. The injured worker also noted neck and left shoulder pain with radiation into the left upper extremity. Associated symptoms included weakness, numbness and headaches. Examination of the lumbar spine revealed tenderness to palpation and spasms on the left side, atrophy of the quadriceps and a decreased range of motion. A straight leg raise was positive on the left. Cervical spine examination revealed tenderness to palpation of the neck and trapezius area, spasms and a decreased range of motion. The treating physician's plan of care included a request for the medications Neurontin 600 mg # 90, Soma 350 mg # 60, Ibuprofen 800 mg # 90 and Norco 325 mg/10 mg # 60.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Neurontin 600 mg Qty 90, 1 capsule 3 times daily:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 18-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs Page(s): 18-19.

**Decision rationale:** MTUS guidelines state that antiepileptic drugs are recommended for neuropathic pain. Gabapentin is recommended on a trial basis with lumbar spinal stenosis to assess if there is improved sensation, decreased pain with movement and increased walking distance. The patient should be asked at each visit as to whether there has been a change in pain or function. It is noted that there is no EMG/NCV to document neuropathy in the Injured Worker. There was no documentation of objective functional benefit with prior use of these medications. The request is not medically necessary or appropriate.

**Soma 350 mg Qty 60, 1 tablet by mouth 2 times daily:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain); Carisoprodol (Soma) Page(s): 63-65.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65.

**Decision rationale:** Per MTUS guidelines, Soma is not recommended for longer than a 2 to 3 week period. Carisoprodol is metabolized to meprobamate an anxiolytic that is a schedule IV controlled substance. Carisoprodol is classified as a schedule IV drug in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. The documentation was poorly legible with notation of spasm noted. The duration of treatment is excessive and thus the request is not medically necessary or appropriate.

**Ibuprofen 800 mg Qty 90, 1 tablet 3 times daily:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non steroidal anti-inflammatory drugs) Page(s): 67-68, 71-72.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73.

**Decision rationale:** According to MTUS guidelines NSAID's are recommended as an option for short-term symptomatic relief of chronic low back pain. Naproxen is a non-steroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. According

to the MTUS and ODG guidelines NSAID's are recommended for osteoarthritis, chronic back pain and acute exacerbations of back pain. According to the progress notes provided the Injured Worker was on Naproxen with a diagnosis of chronic bilateral shoulder pain. There is inconsistent evidence for the use of these medications to treat long term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions however it is documented that the Injured Worker takes the ibuprofen up to three times daily. This request is medically necessary and appropriate at this time.

**Norco 10/325 mg, Qty 60, 1 tablet every 12 hrs for 30 days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80, 91, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; 4) On-Going Management; 6) When to Discontinue Opioids; 7) When to Continue Opioids for chronic pain Page(s): 78-80.

**Decision rationale:** The IW has been on long term opioids which is not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary or appropriate.