

Case Number:	CM15-0183001		
Date Assigned:	09/30/2015	Date of Injury:	03/14/2006
Decision Date:	12/01/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	09/17/2015

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: Preventive Medicine, Occupational 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 57 year old female who sustained an industrial injury on 3-14-2006. A review of medical records indicates the injured worker is being treated for lumbar discogenic disease, lumbar radiculitis, and lumbar facet syndrome. Medical records dated 7-9-2015 noted an increase in her lower back pain since her last visit. Pain was rated a 2-5 out 10 with medications and a 6-7 out 10 without medications. Things that increase pain are bending, stooping, lifting, and walking on uneven surfaces. Physical examination noted range of motion of the lumbar spine in AP and lateral plane was restricted due to pain especially in lateral bending and rotation. There was mild tenderness palpated the zygoapophyseal joints of the lower lumbar spine on both sides. Straight leg raising was normal bilaterally. Reflexes were +1. Treatment has included lumbar radiofrequency lesioning that estimates 80% to 85% relief of her axial symptoms and increasing her functional capacity and allows her to accomplish her daily activities with less medication. Medications have included Norco, Ropinirole, Skelaxin, Neurontin, ibuprofen, and Elavil since at least 8-14-2014. Utilization review form dated 9-4-2015 noncertified Ropinirole 0.5mg #30, Amitriptyline HCL 50mg #60, Skelaxin 800mg #90, Neurontin 600mg #60, Ibuprofen 800mg # 90, and Norco 10-325mg #120.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ropinirole 0.5mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Restless legs syndrome (RLS).

Decision rationale: Ropinirole is used to treat restless leg syndrome. According to the Official Disability Guidelines, the diagnostic criteria are the following: There are four essential criteria. (1) An urge to move the legs, usually accompanied by uncomfortable and unpleasant sensations in the legs. Pain is often a primary component (reported as often as 50% of the time). Symptoms may involve the arms or other body parts. (2) The urge to move/unpleasant sensations become worse during periods of rest or inactivity. (3) Movement partially relieves the urge to move/unpleasant sensations (at least as long as the movement continues). & (4) The urge to move/unpleasant sensations are generally worse at night, or only occur at night. There is no documentation of the above criteria. Ropinirole 0.5mg #30 is not medically necessary.

Amitriptyline HCL (Elavil) 50mg, #60: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Amitriptyline.

Decision rationale: According to the Official Disability Guidelines, amitriptyline is a tricyclic antidepressant that is recommended for chronic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. There is documentation supporting the patient's functional improvement with the continued long-term use of Elavil. I am reversing the previous utilization review decision. Amitriptyline HCL (Elavil) 50mg, #60 is medically necessary.

Metaxalone (Skelaxin) 800mg, #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The MTUS states that muscle relaxants are recommended with caution only on a short-term basis. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The patient has been taking the musclerelaxant for an extended period of time far longer than the short-term course recommended by the MTUS. Metaxalone (Skelaxin) 800mg, #90 is not medically necessary.

Gabapentin (Neurontin) 600mg, #60: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-epilepsy drugs (AEDs).

Decision rationale: The MTUS states that gabapentin is an anti-epilepsy drug which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. An adequate trial period for gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. With each office visit, the patient should be asked if there has been a change in the patient's pain symptoms, with the recommended change being at least 30%. There is documentation of functional improvement. I am reversing the previous utilization review decision. Gabapentin (Neurontin) 600mg, #60 is medically necessary.

Ibuprofen 800mg, #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. Guidelines recommend NSAIDs as an option for short-term symptomatic relief. Ibuprofen 800mg, #90 is not medically necessary.

Hydrocodone/APAP (Norco) 10/325mg, #120: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. The MTUS states that opioids may be continued, (a) If the patient has returned to work, or (b) If the patient has improved functioning and pain. The patient reported significant functional improvement with the continued use of Norco. I am reversing the previous utilization review decision. Hydrocodone/APAP (Norco) 10/325mg, #120 is medically necessary.