

Case Number:	CM15-0200929		
Date Assigned:	10/16/2015	Date of Injury:	09/25/2006
Decision Date:	11/25/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	10/13/2015

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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 63 year old male injured worker suffered an industrial injury on 9-25-2006. The diagnoses included lumbar left hemilaminectomy and microdiscectomy, lumbar spondylolisthesis and lumbar herniated disc, radiculitis and disc collapse. On 8-19-2015, the treating provider reported low back pain with left thigh and feet pain rated 10 out of 10. On exam, there was lumbar muscle tenderness with radiation to the left lower extremity. The medical record did not include a trial of TENS or trial of short acting antiepileptic drugs. There was no medical record indication for the use of Cyclobenzaprine. Diagnostics included lumbar magnetic resonance imaging 8-5-2015 multilevel degenerative disc disease with severe bilateral foraminal stenosis. Request for Authorization date was 8-21-2015. The Utilization Review on 9-14-2015 determined non- certification for Horizant extended release 600mg tablet one every 12 hours as needed for ten days, dispense 20 tablets, Cyclobenzaprine 7.5mg tablet 1/2 to 1 tablet every night as needed for 30 days, dispense 90 tablets and TENS unit (CMS 3000) purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Horizant extended release 600mg tablet one every 12 hours as needed for ten days, dispense 20 tablets: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Horizant.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs). Decision based on Non-MTUS Citation BMJ. 2015 Apr 16;350:h1748. doi: 10.1136/bmj.h1748. Epidural steroid injections compared with gabapentin for lumbosacral radicular pain: multicenter randomized double blind comparative efficacy study. Cohen SP1, Hanling S2, Bicket MC3, White RL4, Veizi E5, Kurihara C6, Zhao Z7, Hayek S8, Guthmiller KB9, Griffith SR10, Gordin V11, White MA12, Vorobeychik Y13, Pasquina PF14. J Back Musculoskelet Rehabil. 2009; 22 (1):17-20. doi: 10.3233/BMR-2009-0210. Gabapentin monotherapy in patients with chronic radiculopathy: the efficacy and impact on life quality. Yildirim K1, Deniz O, Gureser G, Karatay S, Ugur M, Erdal A, Senel K.

Decision rationale: Horizant is Gabapentin. According to the MTUS guidelines: Gabapentin (Neurontin) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. Neurontin is also indicated for a trial period for CRPS, lumbar radiculopathy, Fibromyalgia and Spinal cord injury. In this case, there was mention of radiculitis. Although Horizant may be appropriate for this, there was no validation for its use or discussion on its therapeutic response. Failure of other medications was not noted. The request for Horizant is not medically necessary.

Cyclobenzaprine 7.5mg tablet 1/2 to 1 tablet every night as needed for 30 days, dispense 90 tablets: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: According to the MTUS guidelines, Cyclobenzaprine (Flexeril) is more effective than placebo for back pain. It is recommended for short course therapy and has the greatest benefit in the first 4 days suggesting that shorter courses may be better. Those with fibromyalgia were 3 times more likely to report overall improvement, particularly sleep. Treatment should be brief. There is also a post-op use. The addition of Cyclobenzaprine to other agents is not recommended. The claimant had been on Flexeril for an unknown length of time. The current request was not justified. The use of Flexeril (Cyclobenzaprine) for 30 days is not medically necessary.

TENS unit (CMS 3000) purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: According to the MTUS guidelines, a TENS unit is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. It is recommended for the following diagnoses: CRPS, multiple sclerosis, spasticity due to spinal cord injury and neuropathic pain due to diabetes or herpes. In this case, the claimant did not have the above diagnoses. Response to a 1-month trial is unknown. Indefinite use is not recommended. The request for purchasing a TENS unit is not medically necessary.