

Case Number:	CM15-0210676		
Date Assigned:	10/29/2015	Date of Injury:	11/15/2004
Decision Date:	12/10/2015	UR Denial Date:	10/01/2015
Priority:	Standard	Application Received:	10/27/2015

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: 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:

This is a 67 year old male with a date of injury of November 15, 2004. A review of the medical records indicates that the injured worker is undergoing treatment for chronic pain syndrome, degeneration of lumbar intervertebral disc, and cervical post-laminectomy syndrome. Medical records dated July 21, 2015 indicate that the injured worker complained of lower back pain and right lower extremity radiculopathy. Records also indicate that the injured worker was recovering well from right epicondyle release surgery. A progress note dated September 22, 2015 documented complaints similar to those reported on July 21, 2015. Per the treating physician (September 22, 2015), the employee was temporarily totally disabled. The progress note dated September 22, 2015 documented a physical examination that showed a slow, antalgic gait. Treatment has included medications (Gabapentin, Trazodone, and Lidocaine patches since at least May of 2015; Oxycodone), and right lateral epicondyle release (May 28, 2015). The treating physician did not document results of recent urine drug screens. The utilization review (October 1, 2015) partially certified a request for Gabapentin 800mg (original request for one refill) and Trazodone 50mg #0 (original request for two refills), and non-certified a request for Lidocaine patches 5% #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 800mg #90 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: Although Neurontin (Gabapentin) 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; however, submitted reports have not adequately demonstrated the specific symptom relief or functional benefit from treatment already rendered for this chronic 2004 injury. Medical reports have not demonstrated specific change, progression of neurological deficits or neuropathic pain with functional improvement from treatment of this chronic injury in terms of increased ADLs and work status remaining temporarily total disabled, decreased pharmacological dosing and medical utilization for this chronic injury. Previous treatment with Neurontin has not resulted in any functional benefit and medical necessity has not been established. The Gabapentin 800mg #90 with 1 refill is not medically necessary and appropriate.

Trazodone 50mg #30 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness & Stress: Trazodone (2015).

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

Decision rationale: Trazodone hydrochloride (Desyrel) is an antidepressant chemically unrelated to tricyclic, tetracyclic, or other known antidepressant agents and is indicated for the treatment of major depression. MTUS Medical Treatment Guidelines specifically do not recommend for Trazodone. Tolerance may develop and rebound insomnia has been found even after discontinuation, but may be an option in patients with coexisting major depression that is not the case here. There are no evidence-based studies showing indication or efficacy for treatment of trazodone in insomnia. Submitted reports have not demonstrated functional benefit derived from the previous treatment rendered for this chronic 2004 injury. The Trazodone 50mg #30 with 2 refills is not medically necessary and appropriate.

Lidocaine 5% patch #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Lidoderm (lidocaine patch).

Decision rationale: Chronic symptoms and clinical findings remain unchanged with medication refilled. The patient exhibits diffuse tenderness and pain on the exam to the spine and extremities with radiating symptoms. The chance of any type of topical improving generalized symptoms and functionality significantly with such diffuse pain is very unlikely. Topical Lidocaine is indicated for post-herpetic neuralgia, according to the manufacturer. There is no evidence in any of the medical records that this patient has a neuropathic source for the diffuse pain. Without documentation of clear localized, peripheral pain to support treatment with Lidocaine along with functional benefit from treatment since May 2015 already rendered remaining TTD status, medical necessity has not been established. There is no documentation of intolerance to oral medication as the patient is also on other oral analgesics. The Lidocaine 5% patch #30 is not medically necessary and appropriate.