

Case Number:	CM15-0221523		
Date Assigned:	11/17/2015	Date of Injury:	09/09/2014
Decision Date:	12/31/2015	UR Denial Date:	10/19/2015
Priority:	Standard	Application Received:	11/11/2015

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:

The injured worker is a 31-year-old female, who sustained an industrial injury on 9-9-2014. A review of the medical records indicates that the injured worker is undergoing treatment for pain in the thoracic spine, myalgia-myositis, lumbago, thoracic-lumbosacral neuritis-radiculitis, sacroiliitis, lumbosacral spondylosis without myelopathy, and lumbosacral sprain-strain. On 8-18-2015, the injured worker reported the cervical spine pain, numbness, and weakness with radiation to the upper extremities, lower back pain with radiation to lower extremities and severe back spasms with the pain noted to be worse, rated as 10 on a scale of 0 to 10. On 7-14-2015, the injured worker reported her pain as 5 out of 10 with medications and 9 out of 10 without medications. The Primary Treating Physician's report dated 8-18-2015, noted the injured worker's current medications were Norco, prescribed since at least 4-21-2015, Prilosec, prescribed since at least 4-21-2015, Neurontin, prescribed since at least 4-21-2015, Rozerem, prescribed since at least 4-21-2015, and Skelaxin, prescribed since at least 4-21-2015. The physical examination was noted to show tenderness to palpation of the thoracic spine level T5 to T10, lumbar tenderness to palpation from L3 to S1 with facet joint tenderness and positive bilateral straight leg raise. The injured worker was noted to have mid back pain, myofascial pain syndrome of the thoracic spine musculature, lower back pain with radiculopathy, and bilateral sacroiliac joint pain. Prior treatments have included acupuncture. The treatment plan was noted to include continued Neurontin, Prilosec, Rozerem, and Skelaxin, with Norco prescribed, and start of physical therapy. The request for authorization was noted to have requested Prilosec 20mg #60, Naprosyn 550mg #60, Norco 10-325mg #60, Neurontin 600mg #120, and Rozerem 8mg #30. The Utilization Review (UR) dated 10-19-2015, certified the requests for Prilosec 20mg #60 and Naprosyn 550mg #60, and non-certified the requests for Norco 10-325mg #60, Neurontin 600mg #120, and Rozerem 8mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #60: 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): Medications for chronic pain, Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: The patient was injured on 08/09/14 and presents with pain in her lower back and upper back. The request is for Norco 10/325 MG #60. The patient is diagnosed with pain in the thoracic spine, myalgia-myositis, lumbago, thoracic-lumbosacral neuritis-radiculitis, sacroiliitis, lumbosacral spondylosis without myelopathy, and lumbosacral sprain-strain. She has been taking this medication as early as 05/14/15 and treatment reports are provided from 04/21/15 to 08/18/15. There is no RFA provided and the patient is not currently working. MTUS, Criteria for Use of Opioids Section, pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS, Criteria For Use Of Opioids Section, page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS, Criteria for Use of Opioids Section, p77, states that "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS, Medications for Chronic Pain Section, page 60 states that "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity." MTUS, Opioids For Chronic Pain Section, pages 80 and 81 states "There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant radiculopathy," and for chronic back pain, it "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." MTUS, p90 states, "Hydrocodone has a recommended maximum dose of 60mg/24hrs." The 07/07/15 treatment report states that the patient rated her pain as a 6/10. The 07/14/15 treatment report indicates that the patient rated her pain as a 5/10 with medications and a 9/10 without medications. "Report reviewed: CURES." The 08/18/15 treatment report states that the patient rated her pain as a 10/10. In this case, none of the 4 A's are addressed as required by MTUS Guidelines. Although there are general pain scales provided, there are no before and after medication pain scales. There are no examples of ADLs, which neither demonstrate medication efficacy nor are there any discussions provided on adverse behavior/side effects. No validated instruments are used either. No outcome measures are provided as required by MTUS Guidelines. There are no urine drug screens provided to see if the patient is compliant with her prescribed medications. The treating physician does not provide adequate documentation that is required by MTUS Guidelines for continued opiate use. The requested Norco is not medically necessary.

Neurontin 600mg #120: Overturned

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): Anti-epilepsy drugs (AEDs).

Decision rationale: The patient was injured on 08/09/14 and presents with pain in her lower back and upper back. The request is for Neurontin 600 MG #120. The patient is diagnosed with pain in the thoracic spine, myalgia-myositis, lumbago, thoracic-lumbosacral neuritis- radiculitis, sacroiliitis, lumbosacral spondylosis without myelopathy, and lumbosacral sprain- strain. She has been taking this medication as early as 04/21/15. There is no RFA provided and the patient is not currently working. MTUS, Anti-epilepsy drugs (AEDs) Section, pages 18 and 19 has the following regarding Gabapentin: "Gabapentin (Neurontin, Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and post- therapeutic neuralgia and has been considered as a first-line treatment for neuropathic pain." The 07/07/15 treatment report states that the patient rated her pain as a 6/10. The 07/14/15 treatment report indicates that the patient rated her pain as a 5/10 with medications and a 9/10 without medications. The 08/18/15 treatment report states that the patient rated her pain as a 10/10. The patient continues with pain and treater has documented medication efficacy. This request appears reasonable and in accordance with guidelines. Therefore, the request is medically necessary.

Rozeram 8mg #30: 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) Pain (updated 10/5/2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter under Insomnia treatment.

Decision rationale: The patient was injured on 08/09/14 and presents with pain in her lower back and upper back. The request is for rozerem 8 MG #30. The patient is diagnosed with pain in the thoracic spine, myalgia-myositis, lumbago, thoracic-lumbosacral neuritis-radiculitis, sacroiliitis, lumbosacral spondylosis without myelopathy, and lumbosacral sprain-strain. She has been taking this medication as early as 04/21/15. There is no RFA provided and the patient is not currently working. The ODG guidelines, Pain chapter under Insomnia treatment: "(3) Melatonin- receptor agonist: Ramelteon (Rozerem) is a selective melatonin agonist (MT1 and MT2) indicated for difficulty with sleep onset; is nonscheduled (has been shown to have no abuse potential). One systematic review concluded that there is evidence to support the short-term and long-term use of Ramelteon to decrease sleep latency; however, total sleep time has not been improved." Melatonin is supported by ODG for sleep disorders and pain treatment. However, the patient is not diagnosed with any sleep disorders, nor is the requested medication discussed in the recent treatment reports. Therefore, the request is not medically necessary.