

Case Number:	CM14-0120537		
Date Assigned:	08/06/2014	Date of Injury:	12/22/1992
Decision Date:	09/30/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	07/30/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 54-year-old male who reported an injury on 12/22/1992. The mechanism of injury was reported as falling over backwards, hitting his head and neck on the concrete. The diagnoses included complex regional pain syndrome and cervical stenosis. Prior treatments included chiropractic treatment, physical therapy, trigger point injections, cervical epidural steroid injection, facet injections, radiofrequency lesioning, and a TENS unit. Diagnostic studies included an official MRI of the cervical spine performed 08/05/2014 that was noted to show no definite compression of the neural structures in the cervical segment. Surgical history included a laminectomy in 11/2007. Per the 07/11/2014 progress note, the injured worker reported pain in the neck and upper shoulder, radiating into the bilateral arms and hands causing pain, tingling, and numbness. Examination of the neck noted paraspinal muscle spasm bilaterally and trapezius tenderness. Sensation was noted to be diminished to touch in the fingers bilaterally. Current medications included Norco 10/325 mg, Mobic 7.5 mg, Flexeril 5 mg, and Neurontin 100 mg. The treatment plan included continuing his medications. The rationale for the request was not provided. The Request for Authorization form was not present in the medical record.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #90 #270: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 76-80.

Decision rationale: The request for Norco 10/325 mg quantity 90, quantity 270 is not medically necessary. The California MTUS Guidelines state opioid management should include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The medical records provided indicate an ongoing prescription for Norco 10/325 mg since at least 04/16/2014. A pain assessment was not provided. It was noted the most recent urine drug test was acceptable. There is a lack of documentation regarding significant pain relief, objective functional improvements, and side effects. Based on this information, continued use is not supported. As such, the request for Norco 10/325 mg quantity 90, quantity 270 is not medically necessary.

Neurontin 100mg #90 #270: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-22.

Decision rationale: The request for Neurontin 100 mg quantity 90, quantity 270 is not medically necessary. The California MTUS Guidelines state 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. After the initiation of treatment, there should be documentation of pain relief and improvement in function, as well as documentation of side effects incurred with use. The medical records provided indicate an ongoing prescription for Neurontin since at least 05/15/2014. Per the 01/21/2014 progress report, the injured worker's allergies included Neurontin. Per the 07/11/2014 progress report, the injured worker was noted to have no known drug allergies. Nonetheless, there is a lack of documentation regarding significant pain relief, functional improvements, and side effects incurred with use. Based on this information, continued use is not supported. As such, the request for Neurontin 100 mg quantity 90, quantity 270 is not medically necessary.

Mobic 7.5mg #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 Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

Decision rationale: The request for Mobic 7.5mg #90 is not medically necessary. The California MTUS Guidelines state NSAIDs are recommended at the lowest dose for the shortest period of time. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain.

The medical records provided indicate an ongoing prescription for Mobic since at least 01/21/2014. The injured worker continued to report radiating pain with tingling and numbness. A complete pain assessment was not provided. There is no indication of significant pain relief or objective functional improvements with the use of Mobic. In addition, the guidelines state NSAIDs are recommended for the shortest period and are not indicated for neuropathic pain. Based on this information, continued use is not supported. As such, the request for Mobic 7.5mg #90 is not medically necessary.

Effexor XR 37.5mg #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 Treatment Guidelines Venlafaxine (Effexor) Page(s): 123.

Decision rationale: The request for Effexor XR 37.5 #90 is not medically necessary. The California MTUS Guidelines state Effexor is recommended as an option in first-line treatment of neuropathic pain. The medical records provided indicate an ongoing prescription for Effexor. The injured worker continued to report radiating pain with numbness, tingling, and depression. A complete pain assessment was not provided. There is no indication of significant pain relief or objective functional improvements with the use of Effexor. In addition, the request for a quantity of 90 is inconsistent with the dosing instructions of once a day. Based on this information, the request is not supported. As such, the request for Effexor XR 37.5 #90 is not medically necessary.