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| Case Number: | CM14-0160453 | | |
| Date Assigned: | 10/06/2014 | Date of Injury: | 11/01/2002 |
| Decision Date: | 11/06/2014 | UR Denial Date: | 08/30/2014 |
| Priority: | Standard | Application Received: | 09/30/2014 |

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 & Rehabilitation and is licensed to practice in Illinois. 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 39-year-old female who reported an injury on 11/01/2002 due to continuous trauma of regular duties. The injured worker had diagnoses of carpal tunnel syndrome, pain syndrome, and lesion of ulnar nerve. Past medical treatment consists of chiropractic therapy, acupuncture, physical therapy, CBT, surgery, injections, the use of a TENS unit, and medication therapy. Medications consist of Lyrica, Norco, Ultram, Xanax, and Soma. Diagnostics were not submitted for review. On 10/01/2014, the injured worker complained of upper extremity pain. Physical examination revealed that the cervical spine was remarkable for flattening of normal lordotic curvature. Markedly diminished grip strength on the right. Positive well healed surgical incision at the right elbow consistent with recent surgery. Positive neural tension signs right upper extremity and positive moderate voluntary guarding of right upper extremity. Medical treatment plan is for the injured worker to continue the use of medication. Rationale and Request for Authorization were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Lyrica 150mg #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs), Page(s): 16, 19-20.

Decision rationale: The request for Lyrica 150mg #60 is not medically necessary. The California MTUS stated that Lyrica is an anticonvulsant that has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has FDA approval for both indications, and is considered first line treatment for both. This medication is designated as a Schedule 5 controlled substance because of its causal relationship with euphoria. This medication also has an antianxiety effect. Pregabalin is being considered by the FDA as treatment for generalized anxiety disorder and social anxiety disorder. The injured worker had no diagnosis of diabetic neuropathy or postherpetic neuralgia. The submitted report dated 10/01/2014 indicated that the injured worker suffered from anxiety and depression. However, the submitted documentation lacked any clear objective findings to support ongoing neuropathic conditions which would reasonably require the use of an anticonvulsant. Although Lyrica is a first line recommended medication in the treatment of neuropathic pain, the documentation did not substantiate the use of this medication. Additionally, the request as submitted did not specify a duration or frequency of the medication. Given the above, this request is not medically necessary.

1 prescription of Hydrocodone Acetaminophen 5/325mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Hydrocodone/APAP) Page(s): 78, 98.

Decision rationale: The request for Hydrocodone/Acetaminophen is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Guidelines state the usual dose is 5/500 mg, 1 or 2 tablets by mouth every 4 to 6 hours as needed for pain, with a max of 8 tablets a day. The guidelines also state that prescription should be from a single practitioner taken as directed, and all prescriptions from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. The MTUS also states that there should be an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessments should include current pain, the least reported pain over the period since last assessment, average pain, and intensity of pain after taking the opioid, how long it takes for pain relief, and how long the pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control is recommended. The submitted documentation did not indicate the efficacy of the medication, nor did it indicate that the medication was helping with any functional deficits. There were also no side effects listed in the submitted reports. Additionally, there was no indication of the injured worker being given any urine drug screens or inpatient treatment. There was also no assessment of the injured worker's pain rates before, during, and after medication with Visual Analog Scale (VAS). Given the above, this request is not medically necessary.

