

Case Number:	CM14-0191280		
Date Assigned:	11/25/2014	Date of Injury:	12/02/2003
Decision Date:	06/22/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	11/17/2014

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. 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: New York

Certification(s)/Specialty: Anesthesiology

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 61-year-old, female who sustained a work related injury on 12/2/03. The diagnoses have included chronic pain syndrome, lumbosacral spondylosis without myelopathy and depressive disorder. The treatments have included a home exercise program, stress reducing techniques, oral medications and Voltaren gel. In the PR-2 dated 10/21/14, the injured worker complains of chronic, low back pain. She has pain that radiates down to right buttock. She rates the pain a 3/10. The treatment plan is requests for oral medications and Voltaren gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 300 mg, sixty count with two refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 17-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) AEDs.

Decision rationale: Neurontin (Gabapentin) is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The records document that the patient has reported radiculopathy related to his chronic low back condition, without evidence of neuropathic pain. There was no documentation of objective findings consistent with current neuropathic pain to necessitate use of Neurontin. Medical necessity for Neurontin has not been established. The requested medication is not medically necessary.

Robaxin 500 mg, 75 count with two refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: Robaxin (Methocarbamol) is an antispasmodic muscle relaxant. The mechanism of action is unknown, but appears to be related to central nervous system depressant effects with related sedative properties. According to CA MTUS Guidelines, muscle relaxants are not recommended for the long-term treatment of chronic pain. They are not recommended to be used for longer than 2-3 weeks. There is no documentation of functional improvement from any previous use of this medication. According to the guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested medication, with 2 refills, is not medically necessary.

Voltaren 1% topical gel, quantity of two with two refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The California MTUS Guidelines state Voltaren gel 1% (Diclofenac) has an FDA appropriation indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment, such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. The submitted documentation does not indicate that the injured worker had a diagnosis of osteoarthritis. Additionally, the efficacy of the medication was not submitted for review, nor was it indicated that it helped with any functional deficits. Medical necessity for the requested topical gel has not been established. The requested 1% Voltaren Gel is not medically necessary.

Cyclobenzaprine 30 mg, sixty count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: According to the reviewed literature, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. In addition, this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. In this case, the available records show that the patient has not shown a documented benefit or any functional improvement from prior Cyclobenzaprine use. In addition, there is no clinical indication presented for the use of 2 muscle relaxants (Cyclobenzaprine and Robaxin). Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested medication is not medically necessary.

Norco 10/325 mg, 150 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97.

Decision rationale: According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's functional benefit. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.