

Case Number:	CM14-0194982		
Date Assigned:	12/02/2014	Date of Injury:	04/20/2007
Decision Date:	01/20/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	11/20/2014

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, has a subspecialty in Interventional Spine 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 patient is a 48-year-old male with date of injury of 04/20/2007. The listed diagnoses from 07/31/2014 are: 1. Cervical degenerative disk disease. 2. Cervical radiculitis. 3. Lumbar degenerative disk disease. 4. Lumbar radiculitis. 5. Right internal derangement. 6. Right knee bursitis. According to this report, the patient complains of persistent neck pain, stiffness, and soreness radiating to both upper extremities, as well as low back pain radiating to both lower extremities. He is also complaining of some mild right knee pain. The patient rates his pain in the neck 5/10 and his back pain 6/10. He states that his medications provide him approximately 40 to 50% relief of his symptomatology and improved function with basic activities of daily living. He also states that transdermal analgesics also "help somewhat" in reducing symptomatology. Examination shows moderate tenderness to palpation of the right and left mid to distal cervical segments as well as the trapezius muscles bilaterally. Sensation is decreased in the right and left C5-C6 dermatomal distribution. Range of motion in the lumbar spine is limited due to pain. Positive axial compression test for the cervical spine. Minimal diffuse tenderness to palpation at the distal lumbar segments. He has some bilateral L5 S1 dermatomal distribution dysesthesia. The documents include progress reports from 05/13/2014 through 11/03/2014. The utilization review certified all request except for Restoril on 11/03/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 600mg quantity 30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines gabapentin Page(s): 18, 19.

Decision rationale: This patient presents with neck and low back pain. The treater is requesting Neurontin 600 mg, quantity 30. The MTUS guidelines pages 18 and 19 on gabapentin states that it has been shown to be effective for the treatment of diabetic peripheral neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. The records do not show that the patient has tried Neurontin in the past. The utilization review certified the request. In this case, given the patient's radiating symptoms, a trial of Neurontin is appropriate to determine its efficacy in terms of pain relief and functional improvement. The request is medically necessary.

Trazodone 100mg quantity 30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants Page(s): 13-15.

Decision rationale: This patient presents with neck and low back pain. The treater is requesting Trazodone 100 mg, quantity 30. The MTUS guidelines pages 13 through 15 on antidepressants states that they are considered the first line option for neuropathic, and there is A possibility for non-neuropathic pain. Tricyclics are generally considered the first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Assessment of treatment efficacy should include not only pain outcomes but also an evaluation of functional changes in use of other analgesic medications, sleep quality, duration, and psychological assessment. The records do not show a history of trazodone use. Given that the MTUS guidelines support the use of Trazodone for neuropathic and non-neuropathic pain, a trial of trazodone is appropriate. The request is medically necessary.

Senokot quantity 60: 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 initiating therapy for opiate use Page(s): 77.

Decision rationale: This patient presents with neck and low back pain. The treater is requesting Senokot quantity 60. The MTUS guidelines page 77 on initiating therapy for opiate use states

that the prophylactic treatment of constipation should be initiated. The records do not show a history of Senokot use. However, the patient is currently not on any opiate. In this case, prophylactic treatment of constipation is only initiated when the patient is on opiate. The request is not medically necessary.

Lexapro 10mg quantity 30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Escitalopram (Lexapro®)

Decision rationale: This patient presents with neck and low back pain. The current request is for Lexapro 10mg quantity 30. Lexapro (escitalopram) is an antidepressant belonging to a group of drugs called selective serotonin reuptake inhibitors (SSRIs). The records do not show a history of Lexapro use. The MTUS guidelines for SSRIs state, "It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain." The ODG guidelines provide further discussion and state, "Recommended as a first-line treatment option for MDD and PTSD." The guidelines also go on to state that it is not recommended for mild symptoms. In this case, the treating physician does not indicate that the patient is suffering from major depression or from post-traumatic stress disorder. The treating physician has not diagnosed the patient with conditions outlined in ODG for the use of Lexapro. The ODG guidelines do not support the current request. The request is not medically necessary.

Restoril 15mg quantity 30: Overturned

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, Insomnia treatment

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepines Page(s): 24.

Decision rationale: This patient presents with neck and low back pain. The treater is requesting Restoril 15 mg, quantity 30. The MTUS guidelines page 24 on benzodiazepines states, "Not recommended for long-term use because long-term efficacy is not proven and there is a risk of dependence. Most guidelines limit the use to 4 weeks" The records do not show a history of Restoril use. Given that the MTUS guidelines support its use for the short-term treatment only, and the requested quantity meets the guidelines, a trial may be appropriate. The request is medically necessary.