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| Case Number: | CM14-0218891 | | |
| Date Assigned: | 01/08/2015 | Date of Injury: | 12/27/2007 |
| Decision Date: | 03/12/2015 | UR Denial Date: | 12/05/2014 |
| Priority: | Standard | Application Received: | 12/30/2014 |

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. 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, Arizona

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 34-year-old female who reported an injury on 12/27/2007. The mechanism of injury was twisting. She was diagnosed with status post right L5-S1 microdiscectomy performed on 07/03/2012. Her past treatments were noted to include medications, surgery, physical therapy, and home exercise program. On 11/12/2014, the patient reported her pain has improved since her previous appointment. She rated her back pain as 5/10 to 6/10 on a pain scale. Upon physical examination, she was noted to have a positive right leg raise test, 5/5 strength with full range of motion in all major joints and myotomes as to right and left and upper and lower extremities, with no structural deformities, except demonstrating limited range of motion in hip flexion secondary to tight hamstrings and limited range of motion secondary to pain. Current medications were noted to include gabapentin 900 mg 3 times a day, Norco 10/325 mg 3 times a day, Norflex 100 mg twice a day, Elavil 10 mg once a day. The treatment plan was noted to include medications and a request for physical therapy, TENS unit, aquatic therapy, and discussion of spinal cord stimulator at next office visit. It was noted the patient's CURES report from 11/12/2014 was consistent with patient's history. A urine drug screen from 07/29/2014 is consistent with history. No signs of misuse, abuse, diversion. A Request for Authorization was submitted on 11/12/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prescription of Gabapentin 600mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain, Antiepilepsy drugs (AEDs) Page(s): 18.

Decision rationale: The request for a prescription of Gabapentin 600 mg, #60, is not medically necessary. The California MTUS Guidelines recommend gabapentin for treatment of diabetic painful neuropathy and post therapeutic neuralgia and has been considered as a first line treatment for neuropathic pain. It was noted that the injured worker has been on the medication since at least 07/2014. The clinical documentation submitted for review does provide evidence of neuropathic pain reported by the patient. However, the documentation submitted for review does not provide evidence of pain relief and no evidence of increased function in performing activities of daily living. Additionally, the request as submitted does not provide a frequency of the medication. Given the above information, the request is not supported by the guidelines. As such, the request for a prescription of Gabapentin 600 mg, #60 is not medically necessary.

Prescription of Gabapentin 600mg, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain, Antiepilepsy drugs (AEDs) Page(s): 18.

Decision rationale: The request for a prescription of Gabapentin 600 mg, #30, is not medically necessary. The California MTUS Guidelines recommend gabapentin for treatment of diabetic painful neuropathy and post therapeutic neuralgia and has been considered as a first line treatment for neuropathic pain. It was noted that the injured worker has been on the medication since at least 07/2014. The clinical documentation submitted for review does provide evidence of neuropathic pain reported by the patient. However, the documentation submitted for review does not provide evidence of pain relief and no evidence of increased function in performing activities of daily living. Additionally, the request as submitted does not provide a frequency of the medication. Given the above information, the request is not supported by the guidelines. As such, the request for a prescription of Gabapentin 600 mg, #30 is not medically necessary.

Prescription of Orphenadrine Citrate 100mg, #60: Upheld

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

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

Decision rationale: The request for a prescription of orphenadrine Citrate 100 mg, #60, is not medically necessary. The California MTUS Guidelines recommend non sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. It was noted this patient has been on the requested medication since at least 07/2014, which surpasses the recommended short term treatment. Additionally, there is no documentation that prior use of the medication has resulted in decreased pain and helped increase mobility. Furthermore, the request as submitted does not specify a frequency of use. In the absence of this documentation, the request is not supported by the guidelines. As such, the request is not medically necessary.

Prescription of Norco 10/325mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 68.

Decision rationale: The request for a prescription of Norco 10/325mg, #90, is not medically necessary. The California MTUS Guidelines state that ongoing management of opioid use should include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. It was noted that the injured worker has been on the medication since at least 07/2014. The clinical documentation submitted for review does provide evidence of consistent urine drug screens, verifying appropriate medication use. However, the clinical documentation submitted for review does not provide evidence of pain relief for the injured worker or evidence that the medication has helped increase the abilities to perform activities of daily living. Based on the documentation provided, the use of the opioid would not be supported by the guidelines. Additionally, the request as submitted does not specify a frequency of use. As such, the request is not medically necessary.

Prescription of Elavil 10mg, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13.

Decision rationale: The request for a prescription of Elavil 10 mg, #30, is not medically necessary. The California MTUS Guidelines note antidepressants are recommended for patients with neuropathic pain as a first line option, especially if pain is accompanied by insomnia, anxiety, or depression. Tricyclics are generally considered first line treatment unless they are ineffective, poorly tolerated, or contraindicated. The guidelines noted antidepressants are recommended for patients with non-neuropathic pain as an option in depressed patients, but

effectiveness is limited. Non-neuropathic pain is generally treated with analgesics and anti-inflammatories. It was noted that the injured worker has been on the medication since at least 07/2014. The clinical documentation provided does not indicate that the patient reported any insomnia, anxiety, or depression. Additionally, the physician did not provide a rationale for the medication. Furthermore, the documentation submitted for review does not indicate that the use of the medication provided pain relief, nor did it indicate increased function to perform activities of daily living. In the absence of this documentation, the request is not supported by the guidelines. Additionally, the request as submitted does not provide a frequency for the medication. As such, the request is not medically necessary.