

Case Number:	CM15-0005241		
Date Assigned:	01/16/2015	Date of Injury:	02/06/1998
Decision Date:	05/18/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/09/2015

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
 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 58-year-old male who reported injury on 02/06/1998. The mechanism of injury was not provided. The most recent documentation submitted for review was dated 10/02/2014. The documentation indicated the injection at the last visit did not give the injured worker much relief. The injured worker had tenderness over the left medial elbow with a positive Tinel's sign. The injured worker was tender over the left shoulder with a positive impingement sign. The diagnoses included recurrent left elbow neuropathy status post previous left ulnar nerve transposition, calcific tendinitis in the left shoulder, status post bilateral carpal tunnel releases, left lateral epicondylitis, and recurrent right carpal tunnel syndrome by nerve conduction study. The treatment plan included a continuation of the anti-inflammatories. The medications included Voltaren 100 mg twice a day, Prilosec 20 mg twice a day, Menthoderm gel apply as directed up to 4 times per day, and tramadol ER 150 mg by mouth twice a day as needed pain, and prednisone with a tapering schedule, and a prescription for Percocet. The documentation submitted for review failed to include a request for the medications and there was no specific physician documentation requesting the medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

Decision rationale: The California MTUS guidelines recommend antiepilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30 % - 50% and objective functional improvement. The clinical documentation submitted for review failed to provide documentation of 30% to 50% pain relief with objective functional improvement. The request as submitted failed to indicate the frequency, quantity, and strength for the requested medication. Additionally, Neurontin is the same medication as gabapentin which was being concurrently reviewed. There was a lack of documentation indicating a necessity for both the generic and brand name for the medication. Given the above, and the lack of documentation, the request for Neurontin is not medically necessary.

Lyrica: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

Decision rationale: The California MTUS guidelines recommend antiepilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30 % - 50% and objective functional improvement. The clinical documentation submitted for review failed to provide documentation of 30% to 50% pain relief with objective functional improvement. The request as submitted failed to indicate the frequency, quantity, and strength for the requested medication. Given the above, and the lack of documentation, the request for Lyrica is not medically necessary.

Cymbalta: Upheld

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

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

Decision rationale: The California MTUS guidelines recommend antidepressants as a first line medication for treatment of neuropathic pain and they are recommended especially if pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective functional improvement to include an assessment in the

changes in the use of other analgesic medications, sleep quality and duration and psychological assessments. The clinical documentation submitted for review failed to include documentation of an objective decrease in pain and objective functional improvement to include an assessment in the changes in the use of other analgesic medications, sleep quality and duration and psychological assessments. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. The request as submitted failed to indicate the frequency, quantity, and strength for the requested medication. Given the above, the request for Cymbalta is not medically necessary.

Gabapentin: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

Decision rationale: The California MTUS guidelines recommend antiepilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30 % - 50% and objective functional improvement. The clinical documentation submitted for review failed to provide documentation of 30% to 50% pain relief with objective functional improvement. The request as submitted failed to indicate the frequency, quantity, and strength for the requested medication. Additionally, Neurontin is the same medication as gabapentin which was being concurrently reviewed. There was a lack of documentation indicating a necessity for both the generic and brand name for the medication. Given the above, and the lack of documentation, the request for gabapentin is not medically necessary.

Valium: Upheld

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

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

Decision rationale: The California MTUS Guidelines do not recommend the use of benzodiazepines for longer than 4 weeks due to the possibility of psychological or physiological dependence. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. The efficacy for the requested medication was not provided. The request as submitted failed to indicate the frequency, quantity, and strength for the requested medication. Given the above, the request for Valium is not medically necessary.

Ambien CR: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Ambien.

Decision rationale: The Official Disability Guidelines indicate Zolpidem (Ambien) is appropriate for the short-term treatment of insomnia, 7-10 days. The clinical documentation submitted for review failed to provide documentation the injured worker had insomnia. The request as submitted failed to indicate the frequency, quantity, and strength for the requested medication. The duration of use cannot be established. However, longer treatment longer than 10 days is not recommended. Given the above, the request for Ambien CR is not medically necessary.

Abilify: Upheld

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

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, Aripiprazole (Abilify).

Decision rationale: Per the Official Disability Guidelines, aripiprazole (Abilify) is not recommended as a first line treatment. It is an antipsychotic medication. There was a lack of documented rationale. The request as submitted failed to indicate the frequency, quantity, and strength for the requested medication. Given the above, the request for Abilify is not medically necessary.

Inderal: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation website: <http://www.drugs.com/inderal.html>.

Decision rationale: Per Drugs.com, Inderal is used to treat tremors, angina, and hypertension, heart rhythm disorders and other heart or circulatory conditions. It is also used to treat or prevent heart attack and to reduce severity and frequency of migraine headaches. The clinical documentation submitted for review failed to provide a rationale for the requested medication. The efficacy was not provided. The request as submitted failed to indicate the frequency, quantity, and strength for the requested medication. Given the above, the request for Inderal is not medically necessary.