

Case Number:	CM15-0125869		
Date Assigned:	07/10/2015	Date of Injury:	04/29/2004
Decision Date:	08/13/2015	UR Denial Date:	06/11/2015
Priority:	Standard	Application Received:	06/29/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 63 year old male, who sustained an industrial injury on 4/29/04. He reported weakness in the left arm while lifting about 25 pounds. The injured worker was diagnosed as having cervical spondylosis, lumbar degenerative disc disease, rotator cuff rupture, status post right and left shoulder surgery with residual adhesive capsulitis, chronic pain syndrome and history of narcotic dependency. Treatment to date has included home exercise program, Norco 5/325mg, chiropractic treatment, acupuncture, injections, spinal cord stimulator and massages. Currently on 5/28/15, the injured worker complains of pain neck, bilateral shoulders and low back, described as constant achy, burning, shooting, throbbing, radiating, squeezing, numbing, cramping and deep, rated 8/10 (on 11/19/14 he rated the pain 9/10). The pain is improved with medications and physical therapy. He is currently not working. Physical exam performed on 5/28/15 noted decreased, painful range of motion of cervical spine and decreased, painful range of motion of bilateral shoulders. A request for authorization was submitted on 6/5/15 for Senokot-S 8.5 mg #120, Horizant 300mg #30 and Norco 7.5/325mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 7.5/325mg 1 tablet oral TID PRN #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-94.

Decision rationale: According to the CA MTUS Norco 7.5/325mg (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. There was no documentation of functional improvement as a result of use of Norco, or relief in pain. Documentation did not include the intensity of pain following administration of the medication or length of time pain relief lasted. A urine drug screen performed 7/14 was noted to be consistent with medications prescribed. Norco has been prescribed at least since 11/19/14. Work status remains off work. There was no documentation of improvement in specific activities of daily living as a result of use of Norco. Therefore this request is not medically necessary.

Horizant 300mg 1 tablet oral #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin, antiepilepsy drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin, antiepilepsy drugs; ODG pain Page(s): 17-19, 49.

Decision rationale: Horizant (gabapentin enacarbil ER) is not recommended as a first line agent. It is FDA approved for treatment of restless leg syndrome. There is no evidence to support use of Horizant for neuropathic pain conditions or fibromyalgia without a trial of generic gabapentin regular release. According to the CA MTUS (2009) and ODG, 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. There is no documentation of subjective or objective findings consistent with current neuropathic pain to necessitate use of Horizant. The injured worker does not have a diagnosis of Restless Leg Syndrome, Diabetes or Post-Herpetic Neuralgia. Work status is currently temporarily totally disabled. Medical necessity for Horizant has not been established. The requested medication is not medically necessary.