

Case Number:	CM13-0014277		
Date Assigned:	10/02/2013	Date of Injury:	05/07/2007
Decision Date:	01/21/2014	UR Denial Date:	08/14/2013
Priority:	Standard	Application Received:	08/20/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine, 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 physician 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.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Patient is a female with a date of injury of May 7, 2007. On March 7, 2013, the patient stated she had low back pain with radiation more on the right. She rated her pain is 6/7 out of 10. She had a 40 to 50% lumbar range of motion moderate spasm and guarding. On April 4, 2013 the patient was on Vicodin twice a day, gabapentin tid, and topical capsaicin cream. She rated her pain 6/7 out of 10. CM 40 to 50% lumbar range of motion with moderate spasm and gardening. There is a note from July 2, 2013 from the treater indicating the patient had a functional improvement however there was no description of her functional improvement given. The doctor's note states that without the medications the patient had difficulty performing activities of daily living and spends more time in bed . The report continues to say that there was clear documentation of medical necessity with their intractable pain with history of lumbar fusion surgery with failed back syndrome. She states that she suffers from chronic pain and uses minimal moderate pain medications to alleviate your pain in improved functional status. There is a note on March 15, 2013 stating that the commission has not been able to reach a therapeutic level of gabapentin due to intolerance to medication. The review of the records shows that there is no clear documentation that there is functional improvement with the medications or the topical analgesic.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 300mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines AED
Page(s): 17.

Decision rationale: CA MTUS chronic pain guidelines state on page 17 that there is insufficient evidence to recommend for or against antiepileptic drugs for axial back pain. In regards to outcome a good response for the use of this medication is a 50% reduction in pain and a moderate response is a 30% reduction in pain. According to the reports there is no reduction of pain as the patient continued to have a 6-7/10 pain. Therefore as guidelines do not have a specific recommendation for this medication for this condition, and there is no reduction of pain noted on the medical records this medication is not medically necessary.

Hydrocodone-Acetaminophen 5/500mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid.

Decision rationale: CA MTUS chronic pain guidelines state that to continue opioid treatment there must be a clear improvement in functional status or decrease in pain as a previous reports and noted there had been no significant decrease in the patient's pain which she rated 7 out of 10. The treating physician did think there was improvement in functional status however he did not clearly define that improvement function. The patient continued to need medication to treat her pain and her function according to the physical exam remained the same. Therefore as there is no clear improvement function status for reduction in pain, the medication is not medical necessary.

Capsaicin Cream 120 grams is: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s):
28.

Decision rationale: The patient requested capsaicin cream under the name Zostrix. This is a 0.025% formulation. On page 28 of the chronic pain guidelines MTUS states an indication for this topical cream is chronic nonspecific back pain. The formulation of the cream requested fits under guidelines. In addition, the topical agent is recommended when other conventional treatments have failed. Therefore as this medication is recommended by guidelines and is indicated for this particular condition, the topical cream is medically necessary.