

Case Number:	CM13-0020188		
Date Assigned:	06/06/2014	Date of Injury:	05/25/2005
Decision Date:	07/11/2014	UR Denial Date:	08/14/2013
Priority:	Standard	Application Received:	09/04/2013

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 Neurological Surgery 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 claimant is a 45-year-old individual who sustained an injury on 5/25/2005. The mechanism of injury was not listed. At the most recent office visit, on 4/22/2014, the claimant reported chronic bilateral upper extremity, neck and back pain. Physical examination demonstrated that he was alert and oriented to person, place and time without signs of sedation, normal lumbar lordosis without scoliotic deformity, antalgic gait and ambulated into the room without any assistance. MRI of the lumbar spine showed acute on chronic motion segment instability with a disc protrusion at L4/5, and a disc bulge slightly flattening the left L5 nerve root with moderate bilateral foraminal narrowing at L5/S1. Plain radiographs of the lumbar spine showed no instability with flexion or extension views. Diagnoses: Thoracic outlet syndrome, lumbar disc displacement, neck pain and lumbago. Current medications include: gabapentin 600 mg, Pantoprazole 20 mg, Norco 5/325 mg, Meloxicam 15 mg, Acyclovir 400 mg, Combivir, Sertraline 100 MG and Sustiva 600 mg. A request was made for prescriptions of Protonix 20 mg #120, Diclofenac Sodium 1.5% 60 gm #2 and gabapentin 600 mg #120. The utilization review in question was dated 8/14/2013 and rendered the certification for Protonix 20 mg #120 and Gabapentin 600 mg #120. Diclofenac Sodium 1.5% 60 gm #2 was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE PRESCRIPTON OF PROTONIX 20 MG QUANTITY 120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms and Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms and Cardiovascular Risk Page(s): 67-68.

Decision rationale: CA MTUS guidelines support the use of proton pump inhibitors as a gastric protectant for individuals utilizing non-steroidal anti-inflammatory medications. A utilization review, dated 8/14/2013, rendered a medical necessity for one prescription of Protonix 20 mg #120. Therefore, this request is considered medically necessary.

ONE PRESCRIPTION OF DICLOFENAC SODIUM 1.5% 60 GM QUANTITY 2: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: CA MTUS guidelines support topical non-steroidal anti-inflammatory medications (NSAIDs) for the short-term treatment of acute pain for short-term use for individuals unable to tolerate oral administration or for whom oral administration is contraindicated. The claimant currently takes Mobic (an oral NSAID). There is no documentation of intolerance or contraindication to first-line therapies, and there is no clinical indication for the use of this medication for the chronic diagnoses listed in the medical records. Therefore, this request is not considered medically necessary.

ONE PRESCRIPTION OF GABAPENTIN 600 MG QUANTITY 120: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 16-20, 49.

Decision rationale: The CA MTUS considers gabapentin to be a first-line treatment for neuropathic pain. A utilization review, dated 8/14/2013, rendered a medical necessity for one prescription of gabapentin 600 mg #120. Based on the clinical documentation provided, there is evidence of neuropathic and radicular pain. As such, the request is considered medically necessary.