

Case Number:	CM13-0033879		
Date Assigned:	12/06/2013	Date of Injury:	04/06/2013
Decision Date:	01/17/2014	UR Denial Date:	10/01/2013
Priority:	Standard	Application Received:	10/10/2013

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. 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 applicant is a represented [REDACTED] employee, who has filed a claim for chronic low back and chronic groin pain reportedly associated with an industrial injury of April 6, 2013. Thus far, the applicant has been treated with the following: analgesic medications; adjuvant medications; MRI imaging of the groin, apparently notable for an inguinal hernia; attorney representation; six sessions of manipulative therapy; seven sessions of acupuncture; unspecified amounts of manipulative therapy; electrodiagnostic testing of October 11, 2013, negative for lumbar radiculopathy; and extensive periods of time off of work. In a utilization review report of October 1, 2013, the claims administrator certified a request for Naprosyn, denied a request for Flexeril, and partially certified a request for Neurontin. The decision on Neurontin is not clearly stated. The applicant's attorney later appealed, on October 8, 2013. An earlier note of August 2, 2013 is handwritten, sparse, not entirely legible, difficult to follow, notable for constant severe low back and groin pain, 8 to 10/10. The applicant is receiving manipulative therapy and acupuncture. An inguinal hernia is evident and is not reducible. Scarring is noted associated with prior inguinal hernia repair surgery. Decreased lumbar range of motion is noted. The applicant is given diagnosis of lumbar radiculopathy and asked to obtain an abdominal ultrasound, pursue additional acupuncture, manipulative therapy, and remain off of work, on total temporary disability. An earlier note of August 6, 2013 does not detail the applicant's medication list. However, the handwritten August 2, 2013 note suggests that no refills of medications were issued on this date and that the applicant was not using any medications as of this date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naprosyn 550 mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 73.

Decision rationale: The attending provider has stated that he intends to employ Naprosyn on a thrice daily basis. As noted on Page 73 of the MTUS Chronic Pain Medical Treatment Guidelines, standard dosing of Naprosyn is twice daily. The dose May be increased to 1500 mg a day for limited periods of time when higher level of analgesic or anti-inflammatory activity is desired. In this case, however, it was not clearly stated why higher analgesic and/or anti-inflammatory activity was needed or desired. It was not clearly stated why standard twice daily dosing of Naprosyn could not be considered here. As noted previously, the documentation on file was sparse, handwritten, and very difficult to follow. Therefore, the request is not certified, on independent medical review.

Cyclobenzaprine (Fexmid) 7.5 mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41.

Decision rationale: As noted on the page 41 of the MTUS Chronic Pain Medical Treatment Guidelines, cyclobenzaprine or Flexeril is not recommended for addition to other agents. In this case, the applicant is using several other analgesic and adjuvant medications. Adding cyclobenzaprine or Flexeril to the mix is not indicated. It is noted that the attending provider has not furnished any compelling rationale or narrative to the request for authorization so as to try and offset the unfavorable MTUS recommendation. Therefore, the request is noncertified

Neurontin 800 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49.

Decision rationale: As noted on Page 49 of the MTUS Chronic Pain Medical Treatment Guidelines, gabapentin or Neurontin is an anticonvulsant medication which is considered first-line treatment for neuropathic pain. In this case, however, the documentation on file is sparse,

handwritten, and not entirely legible. While the claims administrator partially certified request for gabapentin citing September 5, 2013 progress note, said September 5, 2013 progress note was not furnished or attached to application for IMR. The information on file and, specifically, the most recent progress note of August 2, 2013 does not establish the presence of any neuropathic pain for which usage of gabapentin or Neurontin would be indicated. Therefore, the request is not certified