

Case Number:	CM13-0036215		
Date Assigned:	03/19/2014	Date of Injury:	10/10/2011
Decision Date:	04/23/2014	UR Denial Date:	10/08/2013
Priority:	Standard	Application Received:	10/18/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pediatric Rehabilitation Medicine and is licensed to practice in Texas. 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 patient is a 50-year-old male who reported an injury on 10/10/2011. The mechanism of injury was not provided in the medical records. The patient was diagnosed with lumbar radiculopathy and backache unspecified. He is status post L4-L5 discectomy and L4-L5 prosthetic disc replacement on 05/30/2013. The patient's current symptoms include neck pain and back pain radiating from low back down to the left leg and lower back. The patient was noted to have tingling over both hands and both feet. The patient's range of motion was noted to be deferred due to recent surgery. On palpation, paravertebral muscle tenderness and tight muscle band is noted on both sides. Lumbar facet loading is positive on both sides. All lower extremity reflexes were noted to be equal and symmetric. Current medications include Gabapentin 300mg one tablet three times a day, Naproxen 500mg one tablet twice a day, Lunesta 3mg tablet one tablet at bedtime as needed, Norco 10/35 one tablet four times a day as needed for pain, Lipitor 40mg one tablet once a day, and Zanaflex 4mg tablet one tablet twice a day.

IMR ISSUES, DECISIONS AND RATIONALES

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

(RETROSPECTIVE) NAPROXEN 500 MG QUANTITY 360.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID,. Decision based on Non-MTUS Citation MTUS: Chronic Pain Medical Treatment Guidelines, NSAID, 67-68

Decision rationale: According to the California MTUS Guidelines, naproxen is a nonsteroidal anti-inflammatory drug used for the relief of the signs and symptoms of osteoarthritis. NSAIDs are recommended for the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular, or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. The patient is noted to have been taking this medication since at least 03/3013. The documentation submitted for review indicates the patient still has pain symptoms on a continuous basis, relieved somewhat by the current medication. However, the documentation submitted indicated the patient has been using the requested medication for an extended period of time. The documentation also fails to provide objective functional improvement and an objective decrease in the VAS score. As the guidelines state NSAIDs are recommended for short period of time and documentation fails to provide evidence of functional improvement, the request is not supported. Therefore, the request for retrospective naproxen 500 mg, quantity 360.00, is non-certified.

(RETROSPECTIVE) GABAPENTIN 300 MG QUANTITY 540.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTI-EPILEPSY DRUGS GABAPENTIN, Page(s): 16-22.

Decision rationale: According to the California MTUS Guidelines, Gabapentin is shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. The documentation submitted for review indicated the patient's pain level has increased since the last visit and the patient still has pain symptoms on a continuous basis. The documentation submitted failed to provide evidence the requested medication provides pain relief and improvement in function. The request as submitted failed to indicate the frequency in which this medication is to be taken. Therefore, the request for (retrospective) Gabapentin 300 mg, quantity 540.00, is non-certified.