

<b>Case Number:</b>	CM13-0047073		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	07/11/2007
<b>Decision Date:</b>	03/20/2014	<b>UR Denial Date:</b>	10/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2013

### 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 Family Practice, 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 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 patient is a 46-year-old male who reported an injury on 07/11/2007. The mechanism of injury was not specifically stated. The patient is diagnosed with lumbar radiculopathy, status post lumbar spine surgery times 3, chronic pain syndrome, chronic pain-related insomnia, chronic pain-related depression, myofascial syndrome, chronic pain-related anxiety, and neuropathic pain. The patient was seen by [REDACTED] on 10/22/2013. The patient reported persistent pain, anxiety, and insomnia. Objective findings were not provided. Treatment recommendations included continuation of current medications included Subutex, Gabapentin, Anaprox, Protonix, Elavil, Pristiq and Clonazepam.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 300mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

**Decision rationale:** The MTUS Chronic Pain Guidelines state anti-epilepsy drugs are recommended for neuropathic pain. Gabapentin has been shown to be effective for treatment of

diabetic painful neuropathy and postherpetic neuralgia. As per the documentation submitted, there is no evidence of a physical examination documenting any neuropathic pain or neurological deficit. Additionally noted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report high levels of pain. Based on the clinical information received, the request is not medically necessary and appropriate.

**Anaprox 550mg #90:** Upheld

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

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

**Decision rationale:** The MTUS Chronic Pain Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. There is no documentation of objective functional improvement in the medical records provided for review. The MTUS Chronic Pain Guidelines further state there is no evidence of long-term effectiveness for pain or function. Based on the clinical information received, the request is not medically necessary and appropriate.

**Elavil 25mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

**Decision rationale:** The MTUS Chronic Pain Guidelines state antidepressants are recommended as a first-line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain with insomnia. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, change in use of other analgesic medication, or sleep quality and duration. Based on the clinical information received, the request is not medically necessary and appropriate.

**Clonazepam 1mg #45:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** The MTUS Chronic Pain Guidelines state benzodiazepines are not recommended for long-term use, because long-term efficacy is unproven and there is a risk of dependence. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent anxiety with insomnia. The MTUS Chronic Pain Guidelines further state a more appropriate treatment for anxiety disorder is an anti-depressant. Based on the clinical information received, the request is not medically necessary and appropriate.