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| Case Number: | CM13-0063920 | | |
| Date Assigned: | 01/03/2014 | Date of Injury: | 06/22/2010 |
| Decision Date: | 05/12/2014 | UR Denial Date: | 11/26/2013 |
| Priority: | Standard | Application Received: | 12/09/2013 |

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, 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 patient is a 49 year old female who was injured on 6/22/10. The mechanism of injury was lifting and twisting. Prior treatment history has included the completion of six sessions of chiropractic care with good relief. Her medications include Ritalin 20mg, Fosinopril 20mg, Amlodipine 10mg, Trazodone 50mg, and Ketoprofen 75mg. A lumbar spine MRI dated 6/2/11 demonstrated degenerative disc disease at L1-S1, small central protrusion at L5-S1, and mild to moderate bilateral neural foraminal narrowing at L4-4 due to disc facet disease with possible impingement of bilateral L4 nerve roots. Consultation with a psychologist in June of 2012 for the appropriateness of opioid use revealed that the patient is at high risk of opioid abuse due to factors such as family history of depression and substance abuse. In light of these factors, the patient is not a good candidate for opioid medications; specifically, opioids may exacerbate her depression and/or increase her potential of relapsing. A progress note dated 11/14/13 documented the patient to have complaints of low back and bilateral lower extremity pain. She continues to report numbness and tingling in her bilateral lower extremities. She notes increased lower extremity pain and weakness, right greater than left. At a previous visit, she reported that she fell off her bike because her legs gave out. She notes she is still falling occasionally because her legs are going out. The patient rates her pain as 10/10 at the time of the exam. She reports the right leg is giving out. She continues to have severe pain and is unable to perform her activities of daily living. She did not go to her scheduled acupuncture visits due to anxiety over the needles. The EMG/NCV is denied. She reports a better range of motion of the lumbar spine and resolution of her migraine headaches, and was able to increase her activities of daily living. She is having shooting pain in her arms now and wants this addressed. She reports that she is taking Vicodin from a friend some times. The treating physician instructed her that this is not recommended and to discontinue taking her friend's Vicodin. Objective findings on exam

revealed the gait is not antalgic. There are no assistive devices used for walking. The patient is moving around constantly, changing from a sitting position to a standing position. Lumbar range of motion is limited in flexion, extension, lateral rotation, and lateral bending with increase in pain in all planes. Motor strength is 5/5 in the bilateral lower extremities. Sensation is diminished to light touch, pinprick and temperature along all dermatomes bilateral lower extremities. DTRs are 2+ bilateral ankles and 2+ bilateral knees. Straight leg raise test is positive bilaterally for radicular signs and symptoms to 60 degrees. Patrick/Gaenslen's test was negative for SI arthropathy. Pace/Freiberg's test was negative for piriformis syndrome. Her diagnoses include displacement of the lumbar internal disc, degeneration of lumbar disc, and low back pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 GABAPENTIN 300MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16, 19.

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

Decision rationale: According to the guidelines, an anti-epilepsy drug (AED), such as Gabapentin, is recommended for neuropathic pain (pain due to nerve damage). Gabapentin has been shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered a first-line treatment for neuropathic pain. The patient's diagnoses are displacement internal disc, lumbar degeneration of lumbar disc, and low back pain. There are no signs or symptoms of neuropathy. The medical records do not establish the patient has neuropathic pain. There are no documented specific subjective complaints, correlative objective clinical findings, and/or corroborative electrodiagnostic evidence to establish active neuropathy is present. In accordance with the guidelines, the medical necessity of Gabapentin has not been established. The request is noncertified.