

Case Number:	CM14-0102212		
Date Assigned:	07/30/2014	Date of Injury:	10/05/2008
Decision Date:	09/10/2014	UR Denial Date:	06/12/2014
Priority:	Standard	Application Received:	07/02/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 36-year-old male who reported an injury on 10/05/2008. The mechanism of injury was not specifically stated. The current diagnoses include status post positive percutaneous spinal cord stimulator trial, failed back surgery syndrome, status post L5-S1 lumbar fusion, disc protrusion at L5-S1, chronic lumbar radiculopathy, moderate neural foraminal stenosis, grade 1 anterolisthesis, lumbar degenerative disc disease, mild facet joint arthropathy, status post hardware removal at L5-S1 with revision decompression, lumbar sprain, industrially related anxiety, insomnia, and gastrointestinal (GI) upset. The injured worker was evaluated on 06/25/2014 with complaints of bilateral lower back pain with radiation into the bilateral lower extremities. The current medication regimen includes Norco, Aciphex, Ambien, Tizanidine, Ativan, Gabapentin, Celebrex, Cymbalta, OxyContin, Zocor, Metformin, Insulin and Vasotec. Previous conservative treatment also includes TENS therapy. The injured worker's physical examination revealed restricted lumbar range of motion, positive provocative maneuvers, positive lumbar and lower extremity muscle spasm, positive sacroiliac provocative maneuvers, diminished strength in the left lower extremity and positive Lasague's testing and straight leg raising on the left. Treatment recommendations at that time included continuation of the current medication regimen. There was no DWC Form RFA submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #180 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. The injured worker has continuously utilized this medication for an unknown duration. There was no previous physician progress reports submitted for this review. There is no documentation of objective functional improvement upon physical examination. There is also no frequency listed in the request. As such, the request is not medically necessary.

Gabapentin #90 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drug.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 16-19.

Decision rationale: California MTUS Guidelines state gabapentin is recommended for neuropathic pain. The injured worker has continuously utilized this medication for an unknown duration. Despite the ongoing use of this medication, the injured worker continues to present with lower back pain with radiation into the left lower extremity with numbness and paresthesia. Without evidence of objective functional improvement, ongoing use of this medication cannot be determined as medically appropriate. There is also no strength or frequency listed in the request. As such, the request is not medically necessary.