

Case Number:	CM14-0135076		
Date Assigned:	08/29/2014	Date of Injury:	02/10/2004
Decision Date:	09/26/2014	UR Denial Date:	07/26/2014
Priority:	Standard	Application Received:	08/21/2014

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 Family Practice and is licensed to practice in Texas and Massachusetts. 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 44-year-old male who reported an injury on 02/01/2004. The mechanism of injury was not provided for clinical review. The diagnoses included lumbago, pain in the thoracic spine, and psychosexual dysfunction. Previous treatments included medication. Within the clinical note dated 07/17/2014, it was reported the injured worker complained of increased pain in the back. He rated his 5/10 in severity. The injured worker reported having neuropathic pain in the right lower extremity. Upon physical examination, the provider noted the lower extremity strength was 4/5 at the right hip and knee was 5/5 in the rest of the lower extremity. The provider noted the injured worker had sensation intact to light touch in the lower extremity except decreased sensation in the left medial calf. The provider noted tenderness in the left greater than right paraspinal region. The range of motion of the back was flexion at 40 degrees and extension at 0 degrees due to pain. The provider requested Neurontin for pain and Ultram for pain. The request for authorization was provided and submitted; however, was not dated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 300mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs).

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

Decision rationale: The request for Neurontin 300 mg #90 is not medically necessary. The California MTUS Guidelines state gabapentin, also known as Neurontin, has been shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

Ultram ER 100mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

Decision rationale: The request for Ultram ER 100 mg #30 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. The provider did not document an adequate and complete pain assessment within the documentation. There is a lack of documentation indicating the medication had been providing objective functional benefit and improvement. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore, the request is not medically necessary.