

<b>Case Number:</b>	CM14-0171676		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	07/19/2012
<b>Decision Date:</b>	12/02/2014	<b>UR Denial Date:</b>	10/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/17/2014

### 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 Occupational Medicine, 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:

Patient is a 49 year-old female with date of injury 07/19/2012. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 09/03/2014, lists subjective complaints as low back pain with radicular symptoms down the left leg and left wrist pain. Objective findings: Examination of the lumbar spine revealed restricted range of motion in all planes due to pain. Tenderness to palpation of the bilateral paravertebral muscles, tight muscle band, and spasm was noted. Lumbar facet loading was negative bilaterally. Straight leg raising test was positive on the left in supine position. Decreased sensation over the L4, L5, and S1 lower extremity dermatomes on the left side. Examination of the left wrist revealed restricted range of motion and tenderness to palpation over the ulnar side. Phalen's sign and Tinel's sign were positive. Diagnosis: 1. Lumbar radiculopathy 2. Low back pain 3. Wrist pain. The medical records provided for review document that the patient has been taking the following medications for at least as far back as six months. Medications are: 1. Gabapentin 300mg, #30 SIG: 1-2 tabs at bedtime 2. Naprosyn 500mg, #60 SIG: 1 twice daily 3. Flector 1.3% Adhesive Patch, #30 SIG: one patch to skin qday.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 300 #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The MTUS states that gabapentin is an anti-epilepsy drug which has been 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. An adequate trial period for gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. With each office visit the patient should be asked if there has been a change in the patient's pain symptoms, with the recommended change being at least 30%. There is no documentation of any functional improvement. Gabapentin 300 #30 is not medically necessary.

**Naprosyn 500mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti Inflammatory Medications Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73.

**Decision rationale:** The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. The patient has been using Naprosyn for at least 6 months. Naprosyn 500mg #60 is not medically necessary.

**Flector 1.3 Percent Adhesive Patch #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

**Decision rationale:** According to the MTUS, Flector patches are indicated for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. The patient is complaining of low back pain, lumbar radicular pain, and wrist pain. Flector patches are not indicated for low back or radicular pain. The patches have been used for at least 6 months, which is longer than the recommended maximum length of time of 12 weeks. Flector 1.3 Percent Adhesive Patch #30 is not medically necessary.