

<b>Case Number:</b>	CM14-0039392		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	04/28/2005
<b>Decision Date:</b>	08/19/2014	<b>UR Denial Date:</b>	03/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2014

### 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 and Rehabilitation, and is licensed to practice in Nevada. 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 records presented for review indicate that this 49 year-old male was reportedly injured on April 28, 2005. The mechanism of injury is noted as "carrying a 500 pound tarp," resulting in a low back injury. The most recent progress note, dated June 10, 2014, indicates that there are ongoing complaints of low back pain with radiation into the bilateral lower extremities. The physical examination demonstrated 6'4", 222 pound individual who was hypertensive (158/114). The gait pattern was described as within normal limits. There was tenderness to palpation in the lower lumbar region. Diagnostic imaging studies reportedly noted a disc lesion at L5 causing a radiculopathy. A repeat MRI in December, 2013 noted a sequestered disc fragment. Previous treatment includes multiple medications, electrodiagnostic study noting a radiculopathy at L5 & S1. A request had been made for multiple medications and was not certified in the pre-authorization process on March 3, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 #240:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78.

**Decision rationale:** When noting the date of injury, the reported mechanism of injury, the findings on physical examination and the parameters outlined in the Chronic Pain Medical Treatment Guidelines, this medication is indicated for the short-term management of moderate to severe breakthrough pain. The pain complaints are constant, there is no identification of breakthrough pain, and there is no noted efficacy or utility with this medication in terms of increased functionality or return to work. Therefore, when considering the facts noted above there is no medical necessity established for continued use of this preparation.

**Zanaflex 4mg #120 5 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

**Decision rationale:** When noting the most current physical examination tempered by the parameters outlined in the Chronic Pain Medical Treatment Guidelines, this medication is noted for the management of spasticity and unlabeled for use in low back pain. Furthermore, this medication is indicated for short-term use only and not chronic or indefinite use. Therefore, when noting the parameters outlined in the Chronic Pain Medical Treatment Guidelines, the medical necessity has not been established in the progress notes presented for review.

**Neurontin 600mg #90 5 refills:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20, 49.

**Decision rationale:** When considering the reported mechanism of injury, identifying the current changes on MRI of a sequestered fragment and taking into consideration the electrodiagnostic assessment of a verifiable radiculopathy at L5 & S1, there is a clinical indication for a neuropathic lesion. While noting that this is effective for the treatment of diabetic painful neuropathy and post-herpetic neuralgia, there is an off label use for neuropathic lesion. The Chronic Pain Medical Treatment Guidelines consider this medication to be a first-line treatment for neuropathic pain. Therefore, when combining the clinical information with the parameters outlined in the Chronic Pain Medical Treatment Guidelines, there is a medical necessity for this medication.

**Relafen 750mg #60 5 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 72.

**Decision rationale:** When noting the most current clinical information presented, and noting that this is a non-steroidal anti-inflammatory there is insufficient clinical data to support the continued use of this medication as there are no specific inflammatory processes noted. There are complaints of low back pain and the guidelines do indicate that medications such as this to deal with chronic low back pain. However, when noting the physical examination parameters identified in the most current progress notes and the limited clinical information presented for review, this requested medication is not clinically indicated.

**Prilosec 20mg 5 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**Decision rationale:** The parameters for this medication is noted in the Chronic Pain Medical Treatment Guidelines state this medication is indicated for treatment of gastroesophageal reflux disease or a gastric protectant for those individuals utilizing non-steroidal medications. It is noted that non-steroidal medications are not clinically indicated. Furthermore, there are no complaints of any Intestinal distress. As such when considering the data presented there is no clinical indication for the continued use of this medication. The medical necessity has not been established in the progress notes presented for review.