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| Case Number: | CM14-0040565 | | |
| Date Assigned: | 06/27/2014 | Date of Injury: | 05/28/1995 |
| Decision Date: | 08/06/2014 | UR Denial Date: | 03/21/2014 |
| Priority: | Standard | Application Received: | 04/04/2014 |

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 Orthopedic Surgery and is licensed to practice in Texas. 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 68 year old male injured on 05/29/95 due to an undisclosed mechanism of injury. Current diagnoses include lumbar stenosis at L2-3 and L3-4, lumbar degenerative disc disease at L2-3 and L3-4, L4 through S1 arthrodesis, and L4 through S1 instrumentation. The clinical documentation indicates the injured worker has undergone prior lumbar fusion in 1998 from L4 through S1 and has had increased pain from back into bilateral lower extremities. The injured worker has reported a significant loss of strength in the left lower extremity, particularly over the last 18 months with significant atrophy of the left calf. The injured worker has also had significant loss of sensation in the left lower extremity. Prior magnetic resonance image showed severe central and foraminal stenosis at L2-3 and L3-4 with severe degeneration with disc space narrowing and desiccation of the discs at L2-3 and L3-4. The injured worker completed stage 2 of laminectomy and decompression at L2 and L3, arthrodesis at L2-3 and L3-4 posterolateral, segmental instrumentation at L3-S1, removal of segmental instrumentation, and local bone graft on 05/13/14. The clinical note dated 06/10/14 indicates the injured worker reported increased strength in the left lower extremity; however, continues to rate back pain at 7/10. Physical examination revealed motor strength decreased for gastroc 2/5 and peroneals 2/5, sensory decreased to L5 distribution, lateral calf, anterior leg, straight leg raise in same position at 75 degrees is negative. The plan of care includes increase activity as tolerated and no lift, bend, stoop, or twist. The initial request for Vicodin 5/500 #60 with 3 refills and Neurontin 300mg #90 with 11 refills was initially non-certified with modification on 03/21/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vicodin 5/500 #60 with 3 refills: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Lumbar Spine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

Decision rationale: As noted on page 77 of the Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. The documentation indicates the injured worker undergoing multiple stages of lumbar surgery. Opioid medications are required for pain management. As such, the medical necessity of Vicodin 5/500 #60 with 3 refills is recommended as medically necessary.

Neurontin 300MG #90 with 11 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Lumbar Spine.

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

Decision rationale: As noted on page 49 of the Chronic Pain Medical Treatment Guidelines, current guidelines recommend Gabapentin for the treatment of neuropathic pain. The clinical documentation establishes the presence of objective findings consistent with neuropathy. However, the request for 11 refills is excessive. As such, the request for Neurontin 300MG #90 with 11 refills is not medically necessary and appropriate.