

Case Number:	CM14-0091846		
Date Assigned:	07/25/2014	Date of Injury:	08/28/1998
Decision Date:	10/01/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	06/17/2014

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 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 injured worker is a 57 year-old male who was reportedly injured on 8/28/1998. The mechanism of injury is not listed. The most recent progress note dated 4/14/2014 indicates that there are ongoing complaints of chronic low back pain. The physical examination demonstrated lumbar spine: reflexes bilateral knee and ankle 1+ symmetric without deficit. There is severe tenderness over the right sacroiliac joint, mild-moderate tenderness of the left. Positive Gillet's test on the right, mildly positive on the left. Fortin finger test is positive on the right, and forward flexion test is positive on the right. Moderate tenderness right here medial L5-S-1 with moderate muscle spasm. Positive facet joint provocation test on the right side, negative on the left. No recent diagnostic studies are available for review. Previous treatment includes radiofrequency ablation, medications, and conservative treatment. Lumbar fusion. A request was made for gabapentin 600mg #90, omeprazole 20mg #30, Norco 10/325 mg #90, and was not certified in the pre-authorization process on 6/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 600mg, one tablet three times daily, #90.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines: Anti-epileptic Medicati.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 16-20, 49.

Decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines considers gabapentin to be a first-line treatment for neuropathic pain. Based on the clinical documentation provided, there is no evidence that the injured employee has any neuropathic pain nor are any radicular symptoms noted on physical examination. As such, this request for Neurontin is not medically necessary.

Omeprazole 20mg one table daily, one month supply.: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines: NSAIDs Non-steroidal An.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 68-69.

Decision rationale: California Medical Treatment Utilization Schedule guidelines support the use of proton pump inhibitors (PPI) in patients taking non-steroidal anti-inflammatory medications with documented gastroesophageal distress symptoms and/or significant risk factors. After review the medical documentation provided it is noted the injured worker does have complaints of gastrointestinal upset with the use of nonsteroidal anti-inflammatory's. Therefore, the continued use of this medication is considered medically necessary.

Norco 10/325mg every eight hours as needed, #90.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines: Identify the Criteria f.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 74-78, 88, 91.

Decision rationale: Norco (hydrocodone/acetaminophen) is a short acting opiate indicated for the management of moderate to severe breakthrough pain. The California Medical Treatment Utilization Schedule guidelines support short-acting opiates at the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain; however, there is no objective clinical documentation of improvement in pain or function with the current regimen. As such, this request for Norco is not medically necessary.