MAXIMUS Federal Services

Case Number:	CM14-0193243		
Date Assigned:	12/01/2014	Date of Injury:	08/10/1993
Decision Date:	01/13/2015	UR Denial Date:	11/07/2014
Priority:	Standard	Application Received:	11/18/2014

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 Emergency 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 with reported date of injury on 8/10/1993. Mechanism of injury is described as cumulative trauma and fall. Patient has a history of chronic pain syndrome, cervicogenic headaches, cervical spondylosis, generalized osteoarthrorosis, degeneration of lumbar and lumbosacral intervertebral disc, adjustment disorder with anxiety/depression and overweight.Medical reports reviewed. Last report available until 10/30/14. Patient complains of neck pain and stiffness, headaches, low back pains, back stiffness, bilateral knee pains and R shoulder pains. Pain is 7/10. Patient reportedly was switched to 2 forms of Morphine Sulfate and recently and it is reportedly "beneficial".Objective exam reveals obese with mild discomfort. Neck with diffuse tenderness right side worst than left side. Decreased range of motion(ROM) with pain. Trapezius and upper thoracic has noted pain. Spurling's is negative. Diffuse lumbar pain with trigger points. No muscle spasms noted. Negative straight leg raise. Facet tenderness. Neurological exam is described as intact. MRI of lumbar spine(10/31/11) reportedly shows bilateral pars interarticularis defects at L5 with grade 1 spondylolisthesis with 8mm of subluxation. Nerve root canals are severely narrowed. Electrodiagnostic studies done on 2/9/12 reportedly showed low amplitude, absent and SNAPs. Negative for radiculopathy or peripheral neuropathy.Current medications include MSIR, MS, Flexeril, Gabapentin, Atenolol, Reglan, Hydroxyzine, Fluoxetine, Enalapril and Tizanidine. Patient has undergone physical therapy, chiropractic and medications,Independent Medical Review is for Gabapentin 600mg #180 with 2refills and Flexeril 10mg #60.Prior UR on 11/7/14 recommended modification of gabapentin to #72 and flexeril was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 600mg #180 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs(AEDs) Page(s): 18-19.

Decision rationale: Gabapentin(Neurontin) is an anti-epileptic drug with efficacy in neuropathic pain. It is most effective in polyneuropathic pain. Pt has prior exams and MRI findings that is not consistent with radicular or neuropathic pain. It is unclear why patient was started on this medication. Pt has been on this medication chronically and there is no documentation of actual benefit. There is no documentation of any objective improvement. The number of refills prescribed is excessive and would basically give the patient 180day supply which is not appropriate as per MTUS guidelines recommending monitoring. Due to lack of documentation of objective improvement, not meeting any indication for use and excessive refills, Neurontin prescription is not medically necessary.

Flexeril 10mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: Flexeril is Cyclobenzaprine, a muscle relaxant. As per MTUS guidelines, evidence show that it is better than placebo but is considered a second line treatment due to high risk of adverse events. It is recommended only for short course of treatment for acute exacerbations. There is some evidence of benefit in patients with fibromyalgia. Patient appears to be on this medications chronically. The number of tablets prescribed does not support intermittent use but likely chronic use which is not recommended as per MTUS Chronic pain guidelines. Flexeril is not medically necessary.