

Case Number:	CM14-0198106		
Date Assigned:	12/08/2014	Date of Injury:	10/02/2008
Decision Date:	01/21/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	11/25/2014

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 Pain Management, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 patient is a 57-year-old woman with sustained a work-related injury on October 2, 2008. Subsequently, the patient developed chronic low back pain. According to a visit note dated November 17, 2014, the patient reported that since her last visit, her quality of life has worsened and her activity level has decreased. The patient had an ESI in April of 2014 with good results, but recently, the low back pain and leg pain were coming back slowly. Examination of the lumbar spine revealed asymmetry of the lumbar spine curvature. Range of motion was restricted with flexion limited to 10 degrees limited by pain, extension, right lateral bending, left lateral bending, lateral rotation to the left and lateral rotation to the right limited by pain. Spinous process tenderness was noted on L4 and L5. Heel and toe walk were normal. Gaenslen's was positive. Lumbar facet loading was positive on both sides. Straight leg raising test was positive on the left side. FEBER test was positive. All lower extremity reflexes were equal and symmetric. The patient was diagnosed with lumbar/thoracic radiculopathy, lumbar spondylosis, lumbar disc degeneration, and low back pain syndrome. The provider requested authorization for Lyrica.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lyrica 75mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Pain Chapter ACOEM Guidelines Chronic Pain Chapter Revised 8/8/08, Page 110

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica Page(s): 20.

Decision rationale: According to MTUS guidelines, Lyrica is an anti-epilepsy drug (AEDs - also referred to as anti-convulsant), which has been shown to be effective for treatment of diabetic; painful neuropathy and post-therapeutic neuralgia; and has been considered as a first-line treatment for neuropathic pain. There is no clear documentation of neuropathic pain in this patient that required and responded to previous use of Lyrica. In addition, the patient was prescribed Gabapentin and there is no documentation of side effects or failure of Gabapentin. There is no clear proven efficacy of Lyrica for back pain. Therefore, Lyrica 75mg #60 is not medically necessary.