MAXIMUS Federal Services

Case Number:	CM14-0201617		
Date Assigned:	12/12/2014	Date of Injury:	10/23/2001
Decision Date:	01/28/2015	UR Denial Date:	11/22/2014
Priority:	Standard	Application Received:	12/02/2014

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 10/23/2001. Mechanism of injury was not provided.Patient has a diagnosis of degeneration of lumbar disc and herniated lumbar disc.Patient is post lumbar fusion at L5-S1 and hardware removal(dates not provided).Medical reports reviewed. Last report available until 10/16/14. Patient complains of chronic low back and lower extremity pains. pain is 5/10. Pain and numbness radiates down legs. Medications reportedly improves pain by "30%" and "good" relief.Objective exam reveals antalgic gait, diffuse lumbar spine tenderness with spasms. Limited range of motion with decreased R lower extremity strength. Decrease sensation to L3-S1 dermatomes. Positive straight leg raise.EMG of bilateral lower extremity(7/21/14) reveals R S1 radiculopathy.Mediations include Gabapentin, Omeprazole, Norco, Ketoprofen and Terocin patches.Patient has undergone chiropractic, acupuncture and physical therapy.Independent Medical Review is for Gabapentin 600mg #60 and Ketoprofen cream.Prior UR on 11/22/14 recommended non-certification. It approved pain management follow up.

IMR ISSUES, DECISIONS AND RATIONALES

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

(1) Prescription of Gabapentin 600mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin), Anti-epilepsy drugs (AEDs).

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

Decision rationale: As per MTUS guidelines, Gabapentin (Neurontin) is an anti-epileptic drug with efficacy in neuropathic pain. It is most effective in polyneuropathic pain. The patient has been on this medication chronically for almost 1 year and there is no documentation of actual benefit. There is no documentation of any objective improvement with only some vague reports of subjective improvement. Therefore, the request for Gabapentin is not medically necessary.

(1) Prescription of Ketoprofen Cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: As per MTUS guidelines, topical creams are considered experimental with poor evidence to support efficacy or use. Topical NSAIDs have no efficacy in spinal pain. Ketoprofen is an NSAID. It is not FDA approved for topical applications. The use of a non-FDA approved application of a medication when there are multiple other topical NSAIDs is not medically necessary. Ketoprofen cream is not medically necessary.