

<b>Case Number:</b>	CM15-0106307		
<b>Date Assigned:</b>	06/10/2015	<b>Date of Injury:</b>	01/31/2007
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 32 year old male, who sustained an industrial injury on 1/31/07. He reported initial complaints of sharp back pain that radiated to the right lower leg. The injured worker was diagnosed as having lumbar degenerative disc disease; lumbosacral neuritis or radiculitis; myofascial pain. Treatment to date has included chiropractic therapy; acupuncture; physical therapy; TENS unit; psychiatric treatment; steroid injections; medications. Currently, the PR-2 notes dated 4/11/15 is hand written and difficult to decipher. The note indicated the injured worker complains of low back pain radiating to the right lower extremity rated at 8-9/10. The provider documents limited range of motion. He also notes the injured workers affect is improved. He discusses medications in his treatment plan and is requesting authorization for Gabapentin 100mg 3 times a day and Norco 10/325mg 3 times a day as needed #70.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg by mouth 3 times a day as needed #70:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

**Decision rationale:** According to MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: "(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug- related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework."According to the patient's file, there is no objective documentation of pain and functional improvement to justify continuous use of Norco. Norco was used for longtime without documentation of functional improvement or improvement of activity of daily living. Therefore, the prescription of Norco 10/325mg #70 is not medically necessary.

**Gabapentin 100mg 3 times a day:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16.

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

**Decision rationale:** According to MTUS guidelines, "Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." There was no documentation that the patient is suffering from neuropathic pain including diabetic neuropathic pain or post-herpetic neuralgia condition. There is no documentation of efficacy and safety from previous use of Gabapentin. Therefore, the prescription of Gabapentin 100mg is not medically necessary.