

Case Number:	CM15-0146960		
Date Assigned:	08/07/2015	Date of Injury:	12/02/2014
Decision Date:	09/04/2015	UR Denial Date:	07/16/2015
Priority:	Standard	Application Received:	07/28/2015

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: Montana, Oregon, Idaho
 Certification(s)/Specialty: Orthopedic Surgery

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 48 year old female, who sustained an industrial injury on December 2, 2014, incurring right shoulder injuries from repetitive job duties. She was diagnosed with a right rotator cuff tear. Magnetic Resonance Imaging of the right shoulder revealed a partial thickness tear of the rotator cuff with tendinosis, a small effusion in the subdeltoid bursa with no adhesive capsulitis. Treatment included physical therapy, pain medications, anti-inflammatory drugs, and modified activities. Currently, the injured worker complained of persistent right shoulder pain. She noted consistent pain upon movement of the shoulder with radiation down into the arm. She rated her shoulder pain a 10 on a pain scale of 1 to 10. She complained that her constant shoulder pain and limited range of motion interfered with her activities of daily living. The treatment plan that was requested for authorization included a prescription for Gabapentin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Gabapentin 100mg #90 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines specific anti-epilepsy drugs Page(s): 18.

Decision rationale: Per the CA MTUS Chronic Pain Treatment Guidelines page 18, Specific Anti-Epilepsy Drugs, Neurontin is indicated for diabetic painful neuropathy and post-herpetic neuralgia and is considered first line treatment for neuropathic pain. In this case, the exam note from 7/15/15 does not demonstrate evidence neuropathic pain or demonstrate percentage of relief, the duration of relief, increase in function or increased activity. Therefore, medical necessity has not been established, and the request for gabapentin is not medically necessary.