

Case Number:	CM15-0198918		
Date Assigned:	10/14/2015	Date of Injury:	09/06/2001
Decision Date:	11/23/2015	UR Denial Date:	10/02/2015
Priority:	Standard	Application Received:	10/09/2015

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 York, Pennsylvania, Washington
 Certification(s)/Specialty: Internal Medicine, Geriatric 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 58 year old female, who sustained an industrial injury on September 6, 2001, incurring left knee, left shoulder and upper and lower back injuries. She was diagnosed with a contusion of the left knee and cervical and lumbar spine strains. Treatment included physical therapy, chiropractic sessions, work hardening program, knee injections, pain medications, neuropathic medications, muscle relaxants, proton pump inhibitor, sleep aides and restricted activities. Electromyography studies revealed peripheral motor neuropathy. Magnetic Resonance Imaging of the knees revealed bilateral meniscus tears and tendinitis. She underwent surgical arthroscopy on both knees. In June 2002, she underwent a right shoulder debridement of a partial rotator cuff tear. Currently, the injured worker complained of significant right greater than left knee pain and persistent low back pain. She noted difficulty with walking using a cane for mobility. She reported decreased pain full range of motion of the knees and low back. The treatment plan that was requested for authorization included one prescription for Tylenol 3 #90 and one prescription for Gabapentin 300 mg #90. On October 1, 2015, a request for Tylenol 3 and Gabapentin was denied by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Tylenol No. 3 #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: Per the guidelines, in opioid use, ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects is required. Satisfactory response to treatment may be reflected in decreased pain, increased level of function or improved quality of life. The MD visit fails to document any significant improvement in pain, functional status or a discussion of side effects specifically related to opioids to justify use per the guidelines. Additionally, the long-term efficacy of opioids for chronic back pain is unclear but appears limited. The medical necessity of Tylenol #3 is not substantiated in the records. Therefore, the request is not medically necessary.

1 prescription of Gabapentin 300mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Per the guidelines, gabapentin 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. For chronic non-specific axial low back pain, there is insufficient evidence to recommend the use of gabapentin. After initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects. The medical records fail to document any improvement in pain, functional status or a discussion of side effects specifically related to gabapentin to justify use. The medical necessity of gabapentin is not substantiated in the records. Therefore, the request is not medically necessary.