MAXIMUS Federal Services

Case Number:	CM15-0024018		
Date Assigned:	02/13/2015	Date of Injury:	11/17/2003
Decision Date:	04/02/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/09/2015

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: Arizona, California
Certification(s)/Specialty: Family Practice

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 43 year old female, who sustained an industrial injury on 11/17/2003. She has reported subsequent low back and gluteal pain and was diagnosed with lumbar discogenic pain, lumbar degenerative disc disease, chronic low back pain, bilateral L5 chronic radiculopathies, lumbar myofascial pain and chronic pain syndrome. Treatment to date has included oral pain medication, epidural steroid injections and application of heat and ice. The utilization review physician indicates that PR-2's from 12/2014 were reviewed however the only medical documentation submitted at this level of review is a progress note from 06/25/2014.According to this progress note, the injured worker complained of low back and gluteal pain radiating to the bilateral lower extremities rated as 9/10 without medications and 5-7/10 with medications. Objective examination findings were notable for tenderness to palpation of the lower lumbar paraspinals with spasms, limited range of motion with pain and pain with straight leg raise in bilateral lower extremities with decreased sensation. There was no documentation submitted pertaining to the current treatment request. On 01/26/2015, Utilization Review modified a request for Neurontin from 60 mg 1 tablet three times a day as needed #90 with 4 refills to 60 mg 1 tablet three times a day as needed #90 with no refills, noting that future requests should be accompanied by clear objectification of radiculopathy to justify continued use. MTUS guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 600mg, 1 tablet by mouth, three times a day as needed, #90 with 4 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neurontin Page(s): 18.

Decision rationale: According to the MTUS guidelines: Gabapentin (Neurontin) 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. Neurontin is also indicated for a trial period for CRPS, lumbar radiculopathy, Fibromyalgia and Spinal cord injury. In this case, the claimant does not have the stated conditions approved for Gabapentin use. Furthermore, the treatment duration was greater the 7 months. Current documentation is not provided as well to determine medication efficacy. The Gabapentin use is not substantiated and is not medically necessary.