

Case Number:	CM15-0040750		
Date Assigned:	03/10/2015	Date of Injury:	11/30/2005
Decision Date:	04/14/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/03/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 41 year old male sustained a work related injury on 11/30/2005. According to a progress report dated 02/04/2015, the injured worker complained of increased low back pain with any movement, bowel and bladder incontinence four times a month, severe bilateral lower extremity spasm with increased pain especially when sitting for a long period of time, abdominal pain, severe lumbar spine pain traveling to the lower extremities with weakness and numbness and severe pain in the shoulder traveling to the finger with weakness and numbness. He also reported headaches, depression and erectile dysfunction. Diagnoses included severe depression with suicidal ideation, headaches, cervical and lumbar spine pain, spinal arachnoiditis, left lower extremity reflex sympathetic dystrophy severe, right mid tib-fib fracture with 3 millimeter displacement of status post open reduction internal fixation, right foot osteopenia severe and occasional bowel and bladder incontinence. Treatment plan included home hand bicycle and exercise ball, Gabapentin, pain management follow-up, Zanaflex, Vicodin, longer back support, right foot orthotic and special shoes, very light wheel chair and new electronic wheelchair, Ambien, Psych follow-up, home shower and house modification including ramp, transportation to/from all medication and legal appointments, nurse case manager, custodial care for activities of daily living including personal hygiene, day care center and gastrointestinal doctor for stomach complaints. The injured worker was temporarily totally disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 7.5/300 Qty: 120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80, 81, 82, 83, 86, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (1) Pain Outcomes and Endpoints, p8, (2) Opioids, criteria for use, p76-80 (3) Opioids, dosing, p86 Page(s): 8, 76-80, 86.

Decision rationale: The claimant is nearly than 10 years status post work-related injury and continues to be treated for chronic back pain. He has undergone multiple lumbar spine surgeries and has a diagnosis of failed back surgery syndrome. Records suggest significant impairment including use of a wheelchair. Guidelines indicate that when an injured worker has reached a permanent and stationary status or maximal medical improvement, that does not mean that they are no longer entitled to future medical care. When prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Hydrocodone/acetaminophen is a short acting combination opioid often used for intermittent or breakthrough pain. In this case, it is being prescribed as part of the claimant's ongoing management. There are no apparent issues of abuse, addiction, or poor pain control. There are no inconsistencies in the history, presentation, the claimant's behaviors, or by physical examination. The total MED being prescribed based on the information submitted is less than 120 mg per day which is within guideline recommendations. Therefore, the continued prescribing of hydrocodone/acetaminophen was medically necessary. (1) Opioids, criteria for use, p76-80 (2) Opioids, dosing, p86

Gabapentin 600mg Qty: 120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs), p16-18 Page(s): 16-18.

Decision rationale: The claimant is nearly than 10 years status post work-related injury and continues to be treated for chronic back pain. He has undergone multiple lumbar spine surgeries and has a diagnosis of failed back surgery syndrome. Records suggest significant impairment including use of a wheelchair. Gabapentin has been shown to be effective in the treatment of painful diabetic neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. When used for neuropathic pain, guidelines recommend a dose titration of at least 1200 mg per day. In this case, the claimant's gabapentin dosing is consistent with recommended guidelines and therefore medically necessary.

