

<b>Case Number:</b>	CM15-0083460		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	07/08/2010
<b>Decision Date:</b>	06/04/2015	<b>UR Denial Date:</b>	04/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2015

### 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: California  
Certification(s)/Specialty: Emergency 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 49 year old female, who sustained an industrial injury on 7/8/2010. She reported injury from a fall. The injured worker was diagnosed as having cervical and lumbar degenerative disc disease, lumbosacral neuritis, right shoulder sprain/strain and chronic pain syndrome. There is no record of a recent diagnostic study. Treatment to date has included physical therapy, psychology visits, TENS (transcutaneous electrical nerve stimulation) and medication management. In a progress note dated 4/7/2015, the injured worker complains of lower back pain that radiates to the bilateral lower extremities, upper back pain with right upper extremity numbness and tingling and right shoulder pain. The pain rating and/or relief from pain were not in the documentation provided for review. The treating physician is requesting Norco 7.5/325mg #45, Valium 10 mg #30 and Gabapentin 300 mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 7.5/325mg #45:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing management Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Opioids for Chronic Pain Page(s): 78-82.

**Decision rationale:** The requested Norco 7.5/325mg #45, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has lower back pain that radiates to the bilateral lower extremities, upper back pain with right upper extremity numbness and tingling and right shoulder pain. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Norco 7.5/325mg #45 is not medically necessary.

**Valium 10mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** The requested Valium 10mg #30, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Benzodiazepines, Page 24, note that benzodiazepines are "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence." The injured worker has lower back pain that radiates to the bilateral lower extremities, upper back pain with right upper extremity numbness and tingling and right shoulder pain. The treating physician has not documented the medical indication for continued use of this benzodiazepine medication, nor objective evidence of derived functional benefit from its previous use. The criteria noted above not having been met, Valium 10mg #30 is not medically necessary.

**Gabapentin 300mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy drugs Page(s): 16-18.

**Decision rationale:** The requested Gabapentin 300mg #30, is not medically necessary. Chronic Pain Medical Treatment Guidelines, Anti-Epilepsy drugs, Pages 16-18, 21, note that anti-epilepsy drugs are "Recommended for neuropathic pain due to nerve damage," and "Outcome: A 'good' response to the use of AEDs has been defined as a 50% reduction in pain and a 'moderate'

response as a 30% reduction." The injured worker has lower back pain that radiates to the bilateral lower extremities, upper back pain with right upper extremity numbness and tingling and right shoulder pain. The treating physician has not documented the guideline-mandated criteria of percentages of relief to establish the medical necessity for its continued use. The criteria noted above not having been met, Gabapentin 300mg #30 is not medically necessary.