

<b>Case Number:</b>	CM14-0105946		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	08/08/2002
<b>Decision Date:</b>	06/30/2015	<b>UR Denial Date:</b>	06/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2014

### 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, West Virginia, Pennsylvania  
 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 59 year old female who sustained an industrial injury on 08/08/2002. Current diagnoses include status post cervical arthodesis with chronic long term cervicgia and status post lumbar decompression and fusion with lumbalgia. Previous treatments included medications, cervical surgeries, lumbar surgeries, epidural injections, psychological evaluation and treatment, physical therapy, and home exercises. Report dated 06/04/2014 noted that the injured worker presented with complaints that included neck pain, bilateral arm pain, low back pain with radiation to the bilateral lower extremities. Pain level was 7-8 out of 10 (neck), 7 out of 10 (arms), and 7-8 out of 10 (low back) on a visual analog scale (VAS). Physical examination was positive for tenderness in the paraspinous musculature of the cervical region and lumbar region, decreased cervical and lumbar range of motion, mild spasm in the cervical area, mild positive head compression, and sensation testing of the lumbar spine is slightly abnormal. The treatment plan included refilling medication and return in 3 months for re-evaluation. Disputed treatments include gabapentin, Celebrex, and Ultram.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 300/600mg, #60 with 2 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 Gabapentin.

**Decision rationale:** Guidelines state that a moderate response to treatment of at least 30% pain relief is required for continuation of gabapentin to be medically appropriate. In this case, documentation is lacking regarding the degree of pain relief. Thus the request for gabapentin 300/500mg #60 with two refills is not medically appropriate and necessary.

**Celebrex 200mg, #60 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Celebrex and NSAIDS (Non-Steroidal Anti-Inflammatory Drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS.

**Decision rationale:** Guidelines caution against long term use of NSAIDs due to the risk of adverse effects and clinical improvement should be observed for continued use. In this case, the patient continued to report high pain levels and there was no evidence of functional improvement with use. The request for Celebrex 200mg #60 with two refills is not medically appropriate and necessary.

**Ultram 50mg, #60 with 2 refills:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ultram (Tramadol), Opioids, Weaning of Medications.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids  
Page(s): 74-96.

**Decision rationale:** Guidelines state opioids are indicated for moderate to severe pain on a short term basis unless there is documented functional improvement. In this case, the patient continued to complain of pain and there was no evidence of measurable functional improvement. The request for Ultram 50mg #60 with 2 refills is medically appropriate and necessary.