

Case Number:	CM14-0212513		
Date Assigned:	01/02/2015	Date of Injury:	10/12/2012
Decision Date:	02/23/2015	UR Denial Date:	12/16/2014
Priority:	Standard	Application Received:	12/18/2014

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: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabn, 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:

The injured worker is a 68-year-old male who reported an injury on 10/12/2012. The mechanism of injury was a trip and fall. The surgical history and other therapyies were not provided. The injured worker underwent electrodiagnostic studies on 01/29/2013 which revealed there was no evidence of left or right lumbar radiculopathy or peripheral neuropathy. The documentation of 12/02/2014 revealed the injured worker had a painful low back, upper back, buttock, and right hip. The injured worker had pain, tenderness, and swelling with no redness or ecchymosis. The injured worker had decreased range of motion on examination. The diagnoses included sprain and strain of the lumbar and thoracic spine and slip and fall accident. The treatment plan included gabapentin 400 mg 3 times a day #90 x10 refills. Additionally, the treatment plan included a pain management consultation for a possible epidural steroid injection. The injured worker had pain on decompression of the lumbar spine. There was a Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Management Consult: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): 1.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend upon ruling out a potentially serious condition, conservative management is provided. If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. The request was submitted with stated purpose to be an epidural steroid injection. The requested consultation would be medically necessary if the injection was found to be medically necessary. However, since the injection is not medically necessary, the request for Pain Management Consult is not medically necessary.

Possible Lumbar Epidural Steroid Injection (ESI): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend epidural steroid injections when there are objective findings of radiculopathy upon physical examination that are corroborated by MRI or electrodiagnostic studies. There should be documentation of a failure of conservative care including exercise, physical medicine, and NSAIDs as well as muscle relaxants. The injured worker underwent electrodiagnostic studies on 01/29/2013 which revealed there was no evidence of left or right lumbar radiculopathy or peripheral neuropathy. There was no MRI submitted for review. There was a lack of documentation indicating the injured worker had objective findings of radiculopathy upon physical examination. There was a lack of documentation of a failure of conservative care including exercise, physical medicine, NSAIDs, and muscle relaxants. There was a lack of documentation indicating a necessity for a lumbar epidural steroid injection. The request as submitted failed to indicate the levels and laterality for the request. Given the above, the request for Possible Lumbar Epidural Steroid Injection is not medically necessary.

Gabapentin #45 0 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that antiepilepsy medications are appropriate as a first line medication for the treatment of

neuropathic pain. There should be documentation of an objective decrease in pain of at least 30% to 50% and objective functional improvement. The clinical documentation submitted for review failed to provide documentation of 30% to 50% pain relief and objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication as well as the strength. Given the above, the request for Gabapentin #45 0 refills is not medically necessary.

Gabapentin #90 (x10 refills): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that antiepilepsy medications are appropriate as a first line medication for the treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30% to 50% and objective functional improvement. The clinical documentation submitted for review failed to provide documentation of 30% to 50% pain relief and objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication as well as the strength. There was a lack of documentation indicating a necessity for 10 refills without documentation of objective decrease in pain of at least 30% to 50% and objective functional improvement. Given the above, the request for Gabapentin #90 (x10 refills) is not medically necessary.