

<b>Case Number:</b>	CM14-0218794		
<b>Date Assigned:</b>	01/08/2015	<b>Date of Injury:</b>	08/06/2007
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	12/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2014

### 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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 56 year old worker has a date of injury 08/06/2007 when she received an industrial injury to the back. In April of 2009, the IW had a L5-S1 disc replacement that was followed by a complication with infection. The IW continued to have back pain and in October 2010 had a L3-L4 fusion with hardware. Back pain improved but the IW continued to have left lower extremity numbness and weakness. She ambulates with a cane since the 2010 surgery. In a qualified medical re-evaluation 10/21/2013, the IW's diagnosis included, status post microscopic posterior lumbar decompression laminotomies from L3 through S1, removal of retained hardware from the L3, L4, and L5 bilaterally, and reconstruction of the dural defect using myofascial autogenous graft. In May 2013, the IW had microscopically assisted posterior lumbar decompression, laminotomies of L3, L4, L5 and S1. The fusion from L3 through S1 was solid and the retained hardware of L3-L4 and L4 was removed bilaterally. A dural defect was reconstructed using myofascial autogenous graft. In the examination of 11/20/2014, the provider notes show that on examination, the IW had decreased lumbar range of motion (ROM) strength at 4/5 with the left tibialis anterior, exterior hallucus longus, peroneal and posterior tibial and gastrocnemius and decreased sensation in the left lower extremity. On 11/26/2014 a request for authorization (ROA) was received by the utilization review agency for Gabapentin 600mg #60 and Prilosec 20mg #60. The IW has documented neuropathic pain, so the Gabapentin, which is shown to be effective in the treatment of painful neuropathic pain and is considered a first-line treatment for neuropathic pain, was approved as medically necessary. Prilosec 20mg #60 was denied based on lack of evidence that the claimant is at significantly increased risk of gastro intestinal events.

California Medical Treatment Utilization Schedule (CA MTUS) NSAIDs, GI symptoms, & cardiovascular risk was cited.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Gabapentin 600mg #60:** 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 Antiepilepsy drugs (AEDs). Page(s): 16-22.

**Decision rationale:** The request for gabapentin 600mg #60 is not medically necessary. MTUS Guidelines state gabapentin has been shown to be effective for diabetic painful neuropathy and postherpetic neuralgia and has been considered a first line treatment for neuropathic pain. After initiation of treatment, there should be documentation of pain relief and improvement in function, as well as documentation of side effects occurred with use. The continued use of an AED depends on improved outcomes versus tolerability and adverse effects. There is no information on treatment history and the length of time the injured worker has been prescribed gabapentin. The efficacy of the prior use of the medication was not documented to support continued use. Additionally, the provider's request does not indicate the frequency of the medication in the request as submitted. As such, medical necessity has not been established.

**prilosec 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Gi symptoms, & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs. Page(s): 68-70.

**Decision rationale:** The request for prilosec 20mg #60 is not medically necessary. According to the California MTUS Guidelines, proton pump inhibitors may be recommended for injured workers with dyspepsia secondary to NSAID therapy or for those taking NSAID medications who are at moderate to high risk for gastrointestinal events. No evidence of the injured worker having moderate to high risk for gastrointestinal events. The injured worker does not have a diagnosis of dyspepsia. As such, medical necessity has not been established