

Case Number:	CM15-0016615		
Date Assigned:	02/04/2015	Date of Injury:	05/06/1991
Decision Date:	03/30/2015	UR Denial Date:	01/07/2015
Priority:	Standard	Application Received:	01/28/2015

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: 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:

The injured worker is a 57-year-old female who reported an injury on 05/12/1991. The mechanism of injury was not provided. Her diagnoses were noted as lumbar radiculopathy, disc protrusion, stenosis, and degenerative disc disease. Her past treatments were noted to include medication, spinal cord stimulator, and activity modification. Her past surgeries were noted to include a percutaneous spinal cord stimulator implant on 04/29/2011. During the assessment on 01/20/2015, the injured worker complained of low back pain that radiated into the bilateral anterolateral and posterior thigh, bilateral anterolateral and posterior calf, and bilateral big toe, with numbness and paresthesias. The physical examination revealed a well healed scar at the site of the spinal cord stimulator incision that was clean, dry, and intact. There was tenderness upon palpation of the proximal IPG site. Lumbar ranges of motion were restricted by pain in all direction. The lumbar discogenic provocative maneuvers were positive. The right sacroiliac joint provocative maneuvers, Patrick's, Gaenslen's, and tenderness at the sacral sulcus were positive. Nerve root tension signs were negative bilaterally, except for positive right straight leg raise, right sitting root, and right Lasegue's signs. The muscle stretch reflexes were symmetric bilaterally in the lower extremities. The clonus, Babinski's, and Hoffman's signs were absent bilaterally. The remainder of the examination was unchanged from the previous visit. The treatment plan was to continue with the current pain regimen and modified duty. The rationale for Norco 10/325 mg was to improve the injured worker's activities of daily living, such as self care and dressing. The rationale for gabapentin was for treatment of neuropathic pain. The Request for Authorization form was dated 01/28/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: The request for Norco 10/325 mg #90 is not medically necessary. The California MTUS Guidelines state that ongoing management of opioid use should include documentation of pain relief, functional status, side effects, and appropriate medication use with use of random drug screening as needed to verify compliance. The guidelines specify that an adequate pain assessment should include the current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long the pain relief lasts. There was no quantified information regarding pain relief. There was a lack of documentation regarding adverse effects and evidence of consistent results on urine drug screens to verify appropriate medication use. Additionally, the frequency was not provided. Given the above, the request is not medically necessary.

Gabapentin 300mg #90 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuropathic pain.

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

Decision rationale: The request for gabapentin 300 mg #90 with 2 refills is not medically necessary. The California MTUS Guidelines recommend antiepilepsy medications 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 did not indicate that there was an objective decrease in pain of at least 30% to 50% or objective functional improvement with the use of gabapentin. Additionally, the frequency was not provided. Given the above, the request is not medically necessary.