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| Case Number: | CM14-0103520 | | |
| Date Assigned: | 07/30/2014 | Date of Injury: | 09/04/1996 |
| Decision Date: | 09/22/2014 | UR Denial Date: | 06/20/2014 |
| Priority: | Standard | Application Received: | 07/03/2014 |

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California and Washington. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 64-year-old male who reported an injury from heavy lifting on 09/04/1996. On 04/07/2014, his diagnoses include post lumbar laminectomy pain, bilateral hip pain and lumbar radiculopathy. His complaints included increasing low back pain which radiated to both hips and his right lower extremity, associated with numbness. It was noted that he was awaiting bilateral hip surgery. He rated his pain at 8/10. His pain was interfering with his sleep. His medications included Percocet 5/325 mg, methadone 5 mg, Neurontin 300 mg, Zanaflex 4 mg, Flector patch 1% and Voltaren gel 1%. There was no rationale or Request for Authorization form included in this worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 300mg 4 times a day: 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) and Gabapentin (Neurontin) Page(s): 16-22; 49.

Decision rationale: The request for Neurontin 300mg 4 times a day is not medically necessary. Per the California Medical Treatment Utilization Schedule (MTUS) Guidelines, anti-epilepsy

drugs are recommended for neuropathic pain, primarily postherpetic neuralgia and painful polyneuropathy, with diabetic polyneuropathy being the most common example. Neurontin specifically has been considered as a first line treatment for neuropathic pain. Neurontin has also been recommended for complex regional pain syndrome. The submitted documentation revealed that this worker had been taking Neurontin since 01/24/2013. There was no documentation of increased functional abilities or decreased pain due to the use of Neurontin. There was no documentation that this injured worker had complex regional pain syndrome or postherpetic neuralgia. The clinical information submitted failed to meet the evidence based guidelines for Neurontin. Therefore, this request for Neurontin 300mg 4 times a day is not medically necessary.