

<b>Case Number:</b>	CM14-0138710		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	08/30/2006
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	08/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/27/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 51-year-old male with a reported injury on 10/30/2006. The mechanism of injury was not provided. The injured worker's diagnoses included chronic left sided low back pain, left lower extremity pain, left sided abdominal pain, and inguinal pain. The injured worker's past treatments included medication. On the clinical note dated 07/22/2014, the injured worker complained of low back pain with radiating symptoms down the left lower extremity. He rated his pain 7/10 before medication and 4/10 after medication. The medical records indicate the medications allow him to carry out activities of daily living and he denies side effects of the medications. The injured worker had increased tenderness to lumbar paraspinal muscles, more on the left, with a positive left leg lift. The injured worker's medications included Neurontin 800 mg 3 times a day, Voltaren gel 4 g 3 times a day, Lidoderm patch 12 hours on 12 hours off, and amitriptyline 10 mg 1 to 2 at night. The request was for Neurontin 1200 mg and Lidoderm patches. The rationale for the request was to increase his Neurontin to 1200 mg and the Lidoderm patches are for low back pain that are a non-narcotic alternative. The Request for Authorization was submitted on 08/04/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Neurontin 1200mg #540:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 18.

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

**Decision rationale:** The request for Neurontin 1200 mg #540 is not medically necessary. The injured worker is diagnosed with chronic left sided low back pain, left lower extremity pain, left sided abdominal pain, and inguinal pain. The injured worker stated his pain before medication was 7/10 and, after medication, 4/10. The California Medical Treatment Utilization Schedule (MTUS) Guidelines recommend anti epilepsy drugs for neuropathic pain. The guidelines state Gabapentin has been shown to be effective for treatment of diabetic and painful neuropathy, postherpetic neuralgia, and has been considered as a first line treatment for neuropathic pain. The injured worker denies side effects from the medications and aberrant behaviors. He is not taking any narcotic medications. The injured worker is noted to be working full time. There is a lack of documentation of quantitative efficacy of relief, functional improvement, and the time frame of efficacy. There is a lack of documentation indicating functional objective deficits. Additionally, the request does not indicate the frequency of the medication. The requesting physician did not provide documentation of rationale for increase from 800 mg Neurontin to 1200 mg Neurontin. As such, the request for Neurontin 1200 mg #540 is not medically necessary.

**Lidoderm patches #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm and topical analgesics Page(s): 56-57, 111-112..

**Decision rationale:** The request for Lidoderm patches #30 is not medically necessary. The injured worker is a diagnosed with chronic left sided low back pain, left lower extremity pain, left sided abdominal pain, and inguinal pain. The injured worker stated his pain before medication was 7/10 and, after medication, 4/10. The California Medical Treatment Utilization Schedule (MTUS) Guidelines state Lidoderm is a brand name for Lidocaine patch. Topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy. The guidelines also recommend topical analgesics for localized peripheral pain. Lidoderm is the only designated orphan status by the FDA for neuropathic pain, for topical Lidocaine formulation. There is a lack of documentation of the quantitative efficacy of relief, functional improvement, and time frame of efficacy. There is a lack of documentation indicating functional objective deficits. There is a lack of documentation indicating failure of first line therapy. Additionally, the request does not indicate the dosage, the application site, and frequency of the patch. As such, the request for Lidoderm patches #30 is not medically necessary.