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| <b>Case Number:</b>   | CM14-0174933 |                              |            |
| <b>Date Assigned:</b> | 10/28/2014   | <b>Date of Injury:</b>       | 04/20/1987 |
| <b>Decision Date:</b> | 12/11/2014   | <b>UR Denial Date:</b>       | 09/26/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/22/2014 |

### 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 Management and is licensed to practice in California. 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:

According to the records made available for review, this is a 63-year-old male with a 5/16/85 date of injury. At the time (9/26/14) of Decision for Terazosin HCL 2mg #60 and Neurontin 600mg #90, there is documentation of subjective (severe back pain radiating to the both legs) and objective (positive straight leg raise, moderate spasm in the lumbar spine, and tenderness to palpitation over the piriformis muscle) findings, current diagnoses (derangement of the knee, essential hypertension, lumbosacral radiculitis, lumbar postlaminectomy syndrome, degeneration of cervical vertebral disc, and lumbosacral spondylosis without myelopathy), and treatment to date (medications (including ongoing treatment with Terazosin and Neurontin since at least 5/6/14)). Regarding Terazosin HCL 2mg #60, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which Terazosin is indicated. Regarding Neurontin 600mg #90, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Neurontin use to date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Terazosin HCL 2mg #60:** 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 Complex Regional Pain Syndrome (CRPS) Page(s): 38. Decision based on Non-MTUS Citation Complex Regional Pain Syndrome (CRPS)

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies terazosin can be helpful in Sympathetically Maintained Pain. ODG does not address this issue. Medical treatment guideline identifies documentation of a condition/diagnosis (with supportive subjective/objective findings) for which Terazosin is indicated (such as: benign prostatic hyperplasia or hypertension). Within the medical information available for review, there is documentation of diagnoses of derangement of the knee, essential hypertension, lumbosacral radiculitis, lumbar postlaminectomy syndrome, degeneration of cervical vertebral disc, and lumbosacral spondylosis without myelopathy. However, despite documentation of a diagnosis of hypertension, there is no documentation of subjective/objective findings that supports the diagnosis. Therefore, based on guidelines and a review of the evidence, the request for Terazosin HCL 2mg #60 is not medically necessary.

**Neurontin 600mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines AEDs, and Specific AEDs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (gabapentin). MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of derangement of the knee, essential hypertension, lumbosacral radiculitis, lumbar postlaminectomy syndrome, degeneration of cervical vertebral disc, and lumbosacral spondylosis without myelopathy. In addition, there is documentation of neuropathic pain. However, given documentation of ongoing treatment with Neurontin, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Neurontin use to date. Therefore, based on guidelines and a review of the evidence, the request for Neurontin 600mg #90 is not medically necessary.