

<b>Case Number:</b>	CM14-0051902		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	02/18/2000
<b>Decision Date:</b>	08/22/2014	<b>UR Denial Date:</b>	04/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/18/2014

### 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 Emergency Medicine 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:

The patient has a reported date of injury on 2/18/2000. No mechanism of injury was provided for review. The patient has a diagnosis of chronic low back pain, left sacroiliac joint pain, failed back syndrome, post posterior lumbar fusion L-S1 and partial fusion L2-3(4/09) and prior laminectomy/discectomy L3-5(8/06). Medical records were reviewed. The last report reviewed was dated 3/17/14. The patient complains of low back pain, sharp and cramping. The patient notes weakness and numbness to legs. Objective exam reveals tenderness to lumbar spine over paravertebral muscles and bilateral quadrates lumborum. Positive straight leg bilateral. Positive Fabre's test. No advance imaging or electrodiagnostic reports were provided. No complete medication list was provided but patient appears to be on opioids and neurontin chronically. Urine Drug screen (12/12/13) was inappropriate with medications being received from other physicians. Independent Medical Review is for Neurontin 300mg #60 with 3 refills. Prior UR on 4/11/14 modified prescription to #45 tablets with no refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NEURONTIN 300MG, #60 WITH 3 REFILLS:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES/GABAPENTIN (NEURONTIN).

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

**Decision rationale:** Records note a reduction of pain of 40% from neurontin. The patient has chronically been on neurontin and it reportedly controls pain. As per MTUS Chronic pain guidelines, 30% improvement in pain with AEDs are considered moderate improvement. Neurontin is a 1st line AED and has been shown to be effective in diabetic neuropathy and post herpetic neuralgia. MTUS guidelines recommend a trial of neurontin for spinal related neuropathic pain. The patient meets moderate improvement threshold with no reported side effects to recommend continuation of therapy. Neurontin is medically necessary.