

<b>Case Number:</b>	CM14-0088198		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	10/26/2011
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	06/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2014

### 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 Nevada. 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 records presented for review indicate that this 46 year-old male was reportedly injured on 10/26/2011. The mechanism of injury is noted as a lifting a bucket of bottles. The most recent progress notes dated 4/11/2014 and 5/23/2014, indicate that there are ongoing complaints of low back pain. Physical examination demonstrated restricted lumbar spine range of motion: flexion 40 degrees and extension 15 degrees; spasm to left paravertebral muscles; positive lumbar facet loading bilaterally; positive left straight leg raising test; motor strength: 4/5 left EHL and dorsiflexion, otherwise 5/5 bilaterally; decreased light touch sensation over left L4, L5 and S1 dermatomes. MRI of the lumbar spine was dated 3/27/2012 and showed several disk protrusions with central canal/foraminal stenosis at L3/4, L4/5 and L5/S1. EMG report dated 2/7/2012 showed mild abnormal electrophysiological studies on the left lower extremity suggestive for radiculopathy in L4-S1 nerve root distribution. Diagnosis: lumbar radiculopathy, low back pain, diabetes mellitus, and methamphetamine use history. Previous treatment includes physical therapy and medications to include Norco, gabapentin, Flexeril, Butrans and Relafen. A request had been made for Neurontin 600mg #120 and Relafen 500mg #60 between 5/21/14 and 7/5/14; which were not certified in the utilization review on 6/9/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Neurontin 600mg #120 between 5/21/14 and 7/5/14: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20, 49 of 127.

**Decision rationale:** MTUS Guidelines considers Gabapentin (Neurontin) to be a first-line treatment for neuropathic and radicular pain. After review of the available medical records, the claimant has signs and symptoms consistent with lumbar radiculopathy confirmed with MRI and EMG of the lower extremities. This request is considered medically necessary.

**Relafen 500mg #60 between 5/21/14 and 7/5/14:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 72 of 127.

**Decision rationale:** Relafen is a nonselective, non-steroidal anti-inflammatory medication with an indication for osteoarthritis per MTUS treatment guidelines. After review of the available medical records, there is no clinical indication for the use of Relafen. As such, this request is not considered medically necessary.