

<b>Case Number:</b>	CM14-0138340		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	05/03/2011
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	08/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
State(s) of Licensure: California, Indiana, New York  
Certification(s)/Specialty: Internal Medicine

### 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 26 year old female who sustained an industrial injury on May 3, 2011. She has reported injury to the low back and has been diagnosed with herniated nucleus pulposus, status post L4-5 decompression, and recurrent disc herniation vs post laminectomy instability. Treatment has included surgery, medical imaging, physical therapy, modified work duty, medications, bracing, a home exercise program, and injections. There was a 4 cm incision over the midline of the lower lumbar spine consistent with a laminectomy. There was tenderness to palpation over the midline of the lower lumbar spine extending into the bilateral paralumbar regions with slight appreciable muscle spasm. Range of motion was decreased. The treatment request included Neurontin and flexeril.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Neurontin 800 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 16-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Gabapentin.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Neurontin (Gabapentin) 800 mg #90 is not medically necessary. Gabapentin is recommended for some neuropathic pain conditions in fibromyalgia. Gabapentin is associated with a modest increase in the number of patients experiencing meaningful pain reduction. Gabapentin is an anti-epilepsy drug (AED). Gabapentin is considered a first-line treatment for neuropathic pain. In this case, the injured worker's working diagnoses are HNP L4 - L5; status post L4 - L5 decompression, September 10, 2012 recurrent HNP with instability; and status post ALDF L4 - L5 December 3, 2013. The documentation shows the injured worker has been on Neurontin as far back as September 10, 2012. The pain scale remains 7/10. The injured worker states her nerve pain has increased because the wrong thing is not authorized. Physical therapy is going well and it decreases her pain. Objectively, the injured worker's reflexes, sensory examination and motor testing for the bilateral upper and lower extremities were normal. Straight leg raising was negative. Gait was normal. There was minimal lumbar tenderness. Range of motion was decreased to 20% flexion of the lumbar spine. There is no objective evidence of functional improvement to support ongoing Neurontin. Consequently, absent clinical documentation with subjective and objective neuropathic complaints and objective findings with ongoing objective functional improvement to support ongoing Neurontin, Neurontin (Gabapentin) 800 mg #90 is not medically necessary.

**Flexeril 10 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Muscle relaxants.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Flexeril 10 mg #90 is not medically necessary. Muscle relaxants are recommended as a second line option short-term (less than two weeks) of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time and prolonged use may lead to dependence. In this case, the injured worker's working diagnoses are HNP L4 - L5; status post L4 - L5 decompression, September 10, 2012 recurrent HNP with instability; and status post ALDF L4 - L5 December 3, 2013. The documentation shows the injured worker has been on Flexeril as far back as September 10, 2012. The pain scale remains 7/10. The injured worker states her nerve pain has increased because the wrong thing is not authorized. Physical therapy is going well and it decreases her pain. Objectively, the injured worker's reflexes, sensory examination and motor testing for the bilateral upper and lower extremities were normal. Straight leg raising was negative. Gait was normal. There was minimal lumbar tenderness. Range of motion was decreased to 20% flexion of the lumbar spine. There is no objective evidence of functional

improvement to support ongoing Flexeril. Flexeril is indicated for short-term (less than two weeks) treatment of an acute exacerbation of chronic low back pain. There is no documentation of an acute exacerbation of chronic low back. Additionally, Flexeril is indicated for short-term (less than two weeks). Flexeril prescribed approximately 22 months prior to the request. The request is in excess of the recommended guidelines for less than two weeks. There is no documentation demonstrating objective functional improvement with ongoing Flexeril. Consequently, absent clinical documentation with objective functional improvement to support ongoing Flexeril use in excess of the recommended guidelines for short-term use (approximately 22 months) and no documentation of an acute exacerbation of chronic low back pain, Flexeril 10 mg #90 is not medically necessary.