

Case Number:	CM15-0009958		
Date Assigned:	01/27/2015	Date of Injury:	07/19/2011
Decision Date:	03/26/2015	UR Denial Date:	01/07/2015
Priority:	Standard	Application Received:	01/16/2015

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, New York, Florida

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care 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 30-year-old male who reported an injury on 07/19/2011 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to his lumbar spine and right knee. The injured worker's treatment history included right knee arthroscopy in 02/2013, multiple medications, physical therapy, and epidural steroid injections. The injured worker was evaluated on 12/15/2014. It was documented that the injured worker had limited range of motion of the lumbar spine secondary to pain. It was documented that the injured worker had tenderness to palpation of the medial femoral condyle of the right knee with a positive patellofemoral compression test and normal range of motion. The injured worker's diagnoses included lumbar spine sprain, right and left sciatica, and right knee internal derangement. The injured worker's medications included Norflex 20 mg, Neurontin 600 mg, and Norco 10/325 mg. The injured worker's treatment plan included continuation of medications. No Request for Authorization form was submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE Neurontin 600mg 1 tab PO QD or as directed #60 (2 bottles): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16, 18.

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

Decision rationale: The requested retrospective Neurontin 600mg 1 tab PO QD or as directed #60 (2 bottles) is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend the use of anticonvulsants, such as Neurontin, as first line medications in the management of chronic pain. However, this is a retrospective request. The date in consideration for the retrospective request was not provided. Therefore, medical necessity of this medication cannot be determined. Additionally, the request includes 2 bottles. This does not allow for timely reassessment or re-evaluation of efficacy of treatment. As such, the retrospective request for Neurontin 600mg 1 tab PO QD or as directed #60 (2 bottles) is not medically necessary or appropriate.

RETROSPECTIVE Norflex 20mg 1 tab PO TID #60 (2 bottles): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The requested Norflex 20mg 1 tab PO TID #60 (2 bottles) is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends muscle relaxants for short durations of treatment to assist in the management of chronic pain. However, this is a retrospective request. No retrospective date was provided. Therefore, medical necessity cannot be determined. Additionally, the request is for 2 bottles. This would be considered in excess of a short duration of treatment. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. As such, the retrospective request for Norflex 20mg 1 tab PO TID #60 (2 bottles) is not medically necessary or appropriate.