

<b>Case Number:</b>	CM15-0044081		
<b>Date Assigned:</b>	03/16/2015	<b>Date of Injury:</b>	11/10/2000
<b>Decision Date:</b>	04/24/2015	<b>UR Denial Date:</b>	03/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/09/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 41-year-old male, who sustained a work/ industrial injury on 11/10/00. He has reported initial symptoms of lower back pain with radiation down the right lower extremity. The injured worker was diagnosed as having right S1 radiculopathy, disk abutting the right at S1 nerve root with annular tear, chronic lumbar discogenic pain. Treatments to date included medication, epidural steroid injection, and home exercise program. Currently, the injured worker complains of ongoing low back pain with right radicular symptoms reported at 8/10 without medications and 4/10 with medications. The treating physician's report (PR-2) from 2/17/15 indicated, per exam, that the lumbar spine showed tenderness on palpation to the bilateral paraspinal muscles, R>L. There was limited and painful range of motion except right lateral bending. Medications included Relafen, Neurontin, Duragesic patch, Zanaflex, Baclofen and Tramadol. Treatment plan included medication refill to include Relafen 750mg and Neurontin 800mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Relafen 750mg, #120:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Nsaids Page(s): 67-72.

**Decision rationale:** Regarding the request for Relafen (nabumetone), Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is indication that Relafan is providing specific analgesic benefits, and the provider states that with the use of all medications (including the Duragesic) the patient's pain score is reduced from 8/10 to 4/10. The provider also documents functional benefit. The denial of this medication appears to have been a misconstruction of the daily dosage. Although #120 pills are dispensed, it is likely that this is a 2-month supply. The patient is documented to be taking Relafen 750mg BID, which is within the guideline recommendation of 2000mg/day. The currently requested Relafan is medically necessary.

**Neurontin 800mg #180:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines AED Page(s): 16-21.

**Decision rationale:** Regarding request for gabapentin (Neurontin), Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is clear documentation of lumbar radiculitis with confirmation on imaging. Therefore, neuropathic pain has been established. There are statements by the requesting provider that gabapentin (along with other concurrent medications) is providing specific analgesic benefits. The provider also documents functional benefit. Although the utilization review determination points to a single increased NRS pain score, it should be known that scores will fluctuate over time, and any particular score cannot be construed as medication failure. Given this, the currently requested gabapentin (Neurontin) is medically necessary.