

<b>Case Number:</b>	CM14-0131196		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	10/27/2008
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	08/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/15/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 58-year-old male with a reported date of injury on 10/27/2008. The mechanism of injury was a fall. The diagnosis is status post lumbar revision surgery. The past treatments included pain medication, acupuncture, physical therapy, chiropractic therapy, and surgery. There was no relevant diagnostic imaging provided. The surgical history included lumbar revision surgery. The subjective complaints on 07/21/2014 included constant lower back pain that radiates to the bilateral lower extremities, greater on the left than the right. The physical examination noted decreased range of motion to the lumbar spine. The injured worker's medications included Norco, Neurontin, and Flexeril. The treatment plan was to order an H wave unit, continue home exercise program, and to refill and continue medications. A request was received for Neurontin, no strength, frequency listed. The Request for Authorization form was dated 07/21/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Neurontin, no strength, frequency listed:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neurontin Page(s): 18-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SPECIFIC ANTI-EPILEPSY DRUGS Page(s): 18.

**Decision rationale:** The California MTUS Guidelines state that Neurontin has been considered as a first line treatment for neuropathic pain. The patient has chronic lower back pain that radiates to the bilateral lower extremities. The notes indicate that several methods of conservative care have been tried and failed. The request for Neurontin would seem appropriate; however, the request does not have strength, frequency, or quantity listed. In the absence of strength, quantity, and frequency, the request is not supported by the evidence-based guidelines. The request for Neurontin, no strength, frequency listed is not medically necessary.