

<b>Case Number:</b>	CM15-0010429		
<b>Date Assigned:</b>	01/28/2015	<b>Date of Injury:</b>	01/03/2002
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	01/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/19/2015

### 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, Hawaii  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 69 year old female, who sustained an industrial injury on 1/3/2002. The diagnoses have included low back pain, arthritis of the back, lumbar degenerative disc disease, myofascial pain, sciatica, hip osteoarthritis and knee osteoarthritis. Surgical history included bilateral hip surgery and left total knee replacement. Treatment to date has included pain medications and injections. According to the Primary Treating Physician's Progress Report from 12/17/2014, the injured worker presented with back pain. She stated her regimen was working well. She also had hip and knee pain. Back pain was described as cramping, shooting, squeezing and tearing. Lumbar exam revealed bilateral tenderness and decreased range of motion. Current medications included Norco, Neurontin, Tramadol, Voltaren Gel and Flexeril. On 1/12/2015 Utilization Review (UR) non-certified a request for 90 Tablets of Flexeril 10mg with two refills, noting that there were no physical examination findings of ongoing muscle spasms. UR non-certified a request for 180 Tablets of Neurontin 600mg with two refills, noting that there were no significant motor or sensory deficits noted on physical exam to suggest pain of neuropathic origin. The MTUS was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Flexeril 10mg #90 with 2 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

**Decision rationale:** The patient presents with pain affecting the low back, bilateral hip, and bilateral knee. The current request is for Retro Flexeril 10mg #90 with 2 refills. The treating physicians report dated 12/17/14 (32G) states, "Flexeril due to severe pain flare up." MTUS guidelines for muscle relaxants state the following: "Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use." MTUS guidelines for muscle relaxants for pain page 63 state the following: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP." MTUS does not recommend more than 2-3 weeks for use of this medication. Medical reports provided, show the patient has been taking Flexeril since at least 7/3/14 (51G). In this case, the use of the medication is outside the 2-3 weeks recommended by MTUS. Recommendation is for denial.

**Retro Neurontin 600mg #180 with 2 refills:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 49.

**Decision rationale:** The patient presents with pain affecting the low back, bilateral hip, and bilateral knee. The current request is for Retro Neurontin 600mg #180 with 2 refills. The treating physicians report dated 12/17/14 (32G) states, "Overall the patient reports 90% improvement with the current regimen with improved pain, range of motion, activity and ADLs." The MTUS guidelines support the usage of Gabapentin for the treatment of radicular pain. MTUS page 60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Reports provided, show the patient has been taking Neurontin since at least 7/3/14. The treating physician notes that the patient's pain is being effectively controlled on her current medication regimen. In this case, the patient experiences a 90% reduction in pain levels while taking Neurontin and documented functional improvement is provided. There is also a diagnosis of sciatic. Furthermore, no side effects from the use of this medication have been reported. Recommendation is for authorization.