

Case Number:	CM13-0030211		
Date Assigned:	11/27/2013	Date of Injury:	08/09/2000
Decision Date:	02/03/2014	UR Denial Date:	09/25/2013
Priority:	Standard	Application Received:	09/30/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation, and is licensed to practice in California. 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 physician 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 patient is a 59 year old male with a date of injury of 8/9/2000. According to the progress report dated 4/11/2013 by [REDACTED], the patient complained of worsening back pain rated 7/10. He also stated that his pain is radiating to his shoulders and the pain worsens as the day progresses. The provider indicated that the examination findings had not changed since the previous visit. Previous relevant objective findings included extremely slow movements, moving in guarded/protective fashion, holding/supporting affected body part and uses a cane with slowed gait. Additional findings included restricted cervical spine range of motion, spinous process tenderness at C5, C6, C7, tremors of the hands bilaterally, restricted lumbar range of motion, difficulty walking on heels and toes and a positive seated straight leg raise on the right side. His diagnoses include cervicobrachial syndrome, post laminectomy syndrome of cervical region, lumbar disc displacement without myelopathy and other general symptom. Prior treatment has consisted of medications, physical therapy, acupuncture, epidural steroid injections, surgery, and home exercises. In a supplemental medical record dated June 13, 2013, the claimant stated that his back pain is worsening now spreading to upper back. He is taking Tramadol 2 in the morning, 2 in the mid day and 2 in the night. He is taking 300 mg 3 pills in the night. His pain level is 8/10 and after taking the pills it is 7/10. He stated that without Neurontin his pain gets worse and with numbness and tingling in right leg. The provider requested for MRI of the lumbar spine without contrast and a prescription of Neurontin 300mg# 90, the latter which is the subject of this independent review.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription for Gabapentin 300mg #90 with 2 refills between 9/9/2013 and 9/9/2013:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Anti-Epileptic Drugs Page(s): s 18-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Anti-Epileptic Drugs Page(s): s 18-19.

Decision rationale: Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. This RCT concluded that gabapentin monotherapy appears to be efficacious for the treatment of pain and sleep interference associated with diabetic peripheral neuropathy and exhibits positive effects on mood and quality of life. It has been given FDA approval for treatment of post-herpetic neuralgia. The number needed to treat (NNT) for overall neuropathic pain is 4. It has a more favorable side-effect profile than Carbamazepine, with a number needed to harm of 2.5. Gabapentin in combination with morphine has been studied for treatment of diabetic neuropathy and postherpetic neuralgia. When used in combination the maximum tolerated dosage of both drugs was lower than when each was used as a single agent and better analgesia occurred at lower doses of each. Recommendations involving combination therapy require further study. According to the MTUS guidelines, Gabapentin should not be abruptly discontinued, although this recommendation is made based on seizure therapy. Weaning and/or switching to another drug in this class should be done over the minimum of a week. An abstract published in Archives of Physical Medicine and Rehab in January 1997 stated "The use of the recently released anticonvulsant, gabapentin (Neurontin), in the treatment of severe and refractory reflex sympathetic dystrophy (RSD) pain in six patients ranging in age from 42 to 68 years is reported. Satisfactory pain relief obtained in all six patients suggests that this medication is an effective treatment for RSD pain. In addition to pain control, early evidence of disease reversal in these patients is suggested. Patient 6 is the first documented case of successful treatment and cure of the RSD pain syndrome using Gabapentin alone. Specifically, reduced hyperpathia, allodynia, hyperalgesia, and early reversal of skin and soft tissue manifestations were noted. Gabapentin was chosen because it has properties similar to other anticonvulsant drugs and because previous studies have shown that it is well tolerated and appears to have a benign efficacy-to-toxicity ratio. It was considered an acceptable and compassionate therapeutic choice because previous medical and surgical approaches had been ineffective for these patients, who represent the first case series documenting the use of gabapentin for pain management. Presently, the mechanism of pain relief in these patients is unknown. In view of encouraging results in these and other RSD patients, further scientific investigation is needed to delineate the role of gabapentin in the treatment of reflex sympathetic dystrophy. The MTUS guidelines did not mention Gabapentin as one of the treatment options for Reflex Sympathetic Dystrophy, however according