

<b>Case Number:</b>	CM14-0170969		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	07/28/2000
<b>Decision Date:</b>	12/03/2014	<b>UR Denial Date:</b>	10/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2014

### 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 Family Medicine and is licensed to practice in Colorado. 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:

52 year old female with date of injury 7/28/2000 continues follow up with treating physician. Patient has had Interbody L4-L5 fusion 2003 and 2004, with some improvement. However, diagnoses include Post Laminectomy Syndrome. Patient has had multiple therapies including opioids, non-steroidal anti-inflammatory drugs, Gabapentin, Cymbalta, Lyrica, multiple muscle relaxers, transcutaneous electrical nerve stimulation (TENS) unit, epidural injection, chiropractic care and aquatic therapy. She is maintained, per the records supplied, on Methadone, Norco, and Skelaxin. Patient reports this regimen helps her accomplish activities of daily living and decreases pain somewhat. Per the 9/15/2014 office visit, patient does report a new symptom of pains in right leg. Otherwise her condition is reported as stable. The treating physician clinic requests approval for continuation of Skelaxin and restart of Gabapentin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Skelaxin 800mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 63, 65.

**Decision rationale:** Per the Guidelines, muscle relaxers are recommended as second line therapy for low back pain, primarily acute exacerbations of chronic issue. Some evidence suggests that muscle relaxers may help decrease pain and muscle spasm and may increase mobility. However, in most cases of low back pain, muscle relaxers do not have any benefit over non-steroidal anti-inflammatory drugs. Appropriate effects of muscle relaxers diminish over time, and long term use with some can lead to dependence. Skelaxin is a non-sedating muscle relaxer with probable mechanism of action suppressing the central nervous system, though exact mechanism of action unknown, as with other muscle relaxers. Per the records, the patient of concern has been taking Skelaxin for at least 3 months. No improvement in overall symptoms documented, though patient reports maintenance achieved with her regimen which includes Skelaxin. The guidelines do not support long term use of muscle relaxers given diminishing effects over time. Per the Guidelines, muscle relaxers are only indicated for short term use. The request for Skelaxin is not medically necessary.

**Neurontin 600mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatment Page(s): 16-18.

**Decision rationale:** Per the Guidelines, Anti-epilepsy drugs (AEDs), including Gabapentin, are recommended for neuropathic pain (Gilron, 2006) (Wolfe, 2004)(Washington, 2005) (ICSI, 2005) (Wiffen-Cochrane, 2005) (Attal, 2006) (Wiffen-Cochrane, 2007) (Gilron, 2007) (ICSI, 2007) (Finnerup, 2007) However, as neuropathic pain can be multifactorial and variable in presentation, there is a lack of agreement on how best to manage it. There is a lack of evidence to support any specific agent in treatment of radiculopathy. Determining which agent to use depends on its effects and any adverse reactions. A "good" response to the use of antiepileptic drugs (AEDs) has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" to change to a different medication or to use a combination of medications. Improvement in symptoms as well as any side effects should be documented when prescribing anti-epilepsy drugs. Gabapentin is considered as first-line treatment for neuropathic pain. (Backonja, 2002) (ICSI, 2007) (Knotkova, 2007) (Eisenberg, 2007) (Attal, 2006), studied primarily in post-herpetic neuralgia and peripheral neuropathy. Gabapentin has also been shown to help improve sleep quality, and elevate mood. When used in combination with Morphine, better analgesia was achieved with lower doses of each. However, there is insufficient evidence to recommend Gabapentin in combination with opioids specifically to reduce opioid dosage. For the patient of concern, it is documented in several office notes that patient has previously tried Gabapentin for her post-laminectomy syndrome. Patient's experience with Gabapentin resulted in "fogginess and short term memory loss," and the pain relief was not significant, per the records. In the records supplied, there is no discussion as to why Gabapentin is being re-tried, and no new indication for which it would be deemed necessary. As patient has had poor response to Gabapentin in the past, with unacceptable side effects. The request for Gabapentin is not medically indicated.

