

<b>Case Number:</b>	CM14-0024326		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	04/15/2008
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	01/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/26/2014

### 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 Internal Medicine and is licensed to practice in Arizona. 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:

This is a 54-year-old man who hurt his lower back while moving fire extinguishers when working as a security officer, April 15, 2008. The record states that he has not worked for the last 3 years; though there is no clarification as to what type of work he performed after his injury and why he ultimately had to quit working. The patient has had physical therapy, and a lumbar epidural injection, May 2, 2013 that gave him about a 30% reduction in his pain. He reports lower back pain with radiation to lower extremities; there is also a statement of having bilateral thigh pain, left side worse than right. On January 7, 2014 he had his third MRI of the lumbar spine which revealed a new left L3-4 paracentral herniated nucleus pulposus. There is a statement that a discitis at L3-4 could not be ruled out. Subsequently he had a whole-body bone scan that was compared to his 2012 bone scan which showed no change (thus nothing concerning for a discitis). He had electrodiagnostic studies including an electromyography (EMG) and a nerve conduction velocity (NCV) on November 13, 2013 that were read essentially normal, except for subtle findings that could reflect possible low-grade peripheral neuropathy. A 7-view set of lumbar x-rays obtained January 9, 2014 showed mild discogenic degenerative disease with malalignment, but no instability and lower lumbar facet arthrosis. The patient has a desire to pursue discussions with a surgeon for a possible fusion, which has been suggested as an option. The patient reports significant pain that limits his activities. He rests frequently and modifies his activity so that he can manage his activities of daily living. Additionally his medications are helpful. They include Gabapentin 800 mg 3 times a day and Norco 10/325 mg, sometimes up to 8 a day. The purpose of this Outside Medical Review is to determine if the Gabapentin 800mg is appropriate for managing his chronic lumbar back pain. The previous Reviewer declined to authorize it, stating there were no good studies using anti-epilepsy drugs

for painful radiculopathy. Additionally, he stated that the patient remained symptomatic and was not working despite using Neurontin (Gabapentin).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**NEURONTIN 800MG TID (3 TIMES A DAY) #2 UNITS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs) Page(s): 16.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs and Gabapentin Page(s): 16-19.

**Decision rationale:** Anti-epilepsy drugs (AEDs) are recommended for neuropathic pain (pain due to nerve damage). There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. Gabapentin, one anti-epileptic, has been shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. This randomized controlled trial concluded that Gabapentin mono therapy 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 postherpetic neuralgia. Gabapentin in combination with morphine has been studied for treatment of diabetic neuropathy and postherpetic neuralgia. When used in combination the maximum tolerated dosages 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. This medication appears to be effective in reducing abnormal hypersensitivity (allodynia and hyperalgesia), to have anti-anxiety effects, and may be beneficial as a sleep aid. Gabapentin has been recommended as a trial in the following specific pain states: spinal cord injury, lumbar spinal stenosis, fibromyalgia, polyneuropathy, chronic regional pain syndrome (CRPS), post-op pain and post stroke, central pain. For chronic nonspecific axial low back pain, a recent review of Topiramate, a different AED, indicated that there is insufficient evidence to recommend for or against anti-epileptic drugs for axial low back pain. AEDs are not recommended for myofascial pain. In the above pain conditions, an adequate trial with Gabapentin is 3-8 weeks for titration, then 1-2 weeks at maximum tolerated dosage. The patient should then be asked at each visit as to whether there has been an improvement in pain or function. Current consensus based treatment algorithms for diabetic neuropathy suggests that if inadequate control of pain is found, a switch to another first-line drug is recommended. Combination therapy is only recommended if there is no change with first-line therapy, with the recommended change being at least 30%. This patient's lower back and bilateral leg pain is not fully defined. He has proven facet and disc disease which can explain the back pain. The records state he has radiculopathy; but, his EMG/NCV did not confirm this; thus his thigh pain is likely something other than radiculopathy. The electrodiagnostic report did suggest a possible low grade peripheral neuropathy, thus giving a potential explanation for the bilateral lower extremity pain. If there was diabetic neuropathy, according to the MTUS, there could be justification for the Gabapentin; but, the record did not indicate if he had diabetes. Part

of determining if Gabapentin is medically necessary, the MTUS has suggested it would be helpful to have documentation indicating if there had been any change in pain or function as a result of the medication. This is not present in the records. There is one statement that the medications helped, but that included the high level of opiates and did not single out the Gabapentin, specifically. In summary, this patient does not have any of the specific pain states in which Gabapentin is recommended as a potential treatment for. Additionally, there is no documentation indicating that the claimant's level of pain or function had improved with its usage. Thus, Gabapentin 800 mg is deemed not medically necessary.