

<b>Case Number:</b>	CM14-0047721		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	11/09/1995
<b>Decision Date:</b>	11/07/2014	<b>UR Denial Date:</b>	03/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2014

### 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:

56 year old male with chronic pain and depression since date of injury 11/9/1995, continues care with the treating physicians. Patient diagnoses include Cervical Degenerative Discs with neck pain / radiculitis, Lumbar Degenerative Discs with low back pain / radiculitis, and Shoulder Pain. Patient has had 3 cervical surgical interventions, physical therapy, cognitive behavioral therapy, and medication therapy, including Methadone, Cymbalta, Gabapentin, Cyclobenzaprine, and Ibuprofen. The records supplied for review show that patient has discontinued Methadone. Per the notes, patient indicates that pain, as of 10/30/2013 evaluation with Psychologist, was "25% of what it was" previous. At that time, notes indicate he was taking only Ibuprofen, Gabapentin, and Cyclobenzaprine. Final notes supplied from the treating physician, are dated 2/10/2014, and medication regimen is unchanged. (Pain Disability Index at that visit indicated high levels of disability in all categories, but there is no previous index for comparison in the records supplied) The treating physician requests authorization for continued Cyclobenzaprine and Gabapentin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 100 MG # 180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 16-19.

**Decision rationale:** Per the guidelines, Gabapentin, an anti-epileptic drug, is recommended for treatment of neuropathic pain, as is the class of anti-epilepsy drugs (AED's). These drugs have been most studied for treatment of post herpetic neuralgia and diabetic neuropathy. Because neuropathic pain is often multifactorial with variable symptoms and physical findings, there is a lack of agreement among experts on the best treatment. There is also a lack of quality evidence for any specific treatment for neuropathic pain with most randomized control trials addressing the above mentioned post-herpetic neuralgia and other polyneuropathies, and few randomized control trials for central pain, none for treatment of radicular pain. As there is a lack of good evidence / expert agreement, per the guidelines, the choice of a specific agent for treatment of neuropathic pain and the decision to continue treatment with a specific anti-epileptic drug are generally determined by efficacy of the medication and any adverse reactions experienced. When using anti-epileptic drugs for treatment of neuropathic pain, the guidelines define a "good" response to the use of AEDs...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" for the following: (1) a switch to a different first-line agent (2) combination therapy if treatment with a single drug agent fails. (Eisenberg, 2007) (Jensen, 2006) Per the guidelines, patient pain levels and functional improvement while taking medications should be documented at follow up appointments. Gabapentin specifically has good evidence to support its use, first-line, in neuropathic pain. (Backonja, 2002) (ICSI, 2007) (Knotkova, 2007)(Eisenberg, 2007) (Attal, 2006) It is FDA-approved for use in post-herpetic neuralgia. In addition to use in neuropathic pain, Gabapentin has evidence to support its use in spinal stenosis, fibromyalgia, spinal cord injury, and some evidence to support its use in post-operative pain to decrease anxiety and need for opioids. Based on the records supplied, patient's pain has decreased 75% while taking the Gabapentin as part of his regimen, documented at a single visit in October 2013 when undergoing mental health evaluation. The records available for review do not specify any functional improvement, only indicating patient has not returned to work and cannot exercise because of pain. The records also do not indicate whether patient was asked if he had any side effects to the Gabapentin. The most recent records supplied from the treating physician are dated 2/10/2014, with no updated information available. Though patient did at one time report significant improvement in pain with Gabapentin as part of his regimen, that was 1 year ago, and there is no documentation then or now that his function improved with Gabapentin. Also, there is no documentatio

**Cyclobenzaprine 10 MG # 30:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Cyclobenzaprine and other antispasmodics are recommended for musculoskeletal pain associated with spasm, but only for a short course. It has been shown to

help more than placebo with back pain and fibromyalgia, but has several side effects that limit its use. Furthermore, Cyclobenzaprine works best in the first 4 days of use, so short courses recommended, no more than 2-3 weeks. No quality consistent evidence exists to support chronic use of Cyclobenzaprine. Common side effects of Cyclobenzaprine include: anticholinergic effects (drowsiness, urinary retention and dry mouth). Sedative effects may limit use. Headache has been noted. This medication should be avoided in patients with arrhythmias, heart block, heart failure and recent myocardial infarction. Side effects limit use in the elderly. (See, 2008) (Toth, 2004) The records supplied indicate patient has been taking Cyclobenzaprine greater than 3 months. As there is no support, per the guidelines, for long term use, the request for Cyclobenzaprine is not medically indicated.