

<b>Case Number:</b>	CM15-0203474		
<b>Date Assigned:</b>	10/20/2015	<b>Date of Injury:</b>	05/08/1997
<b>Decision Date:</b>	12/01/2015	<b>UR Denial Date:</b>	10/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 56 year old female who sustained an industrial injury on 5-8-97. The injured worker reported neck pain. A review of the medical records indicates that the injured worker is undergoing treatments for degeneration of intervertebral disc of cervical region. Medical records dated 10-1-15 indicate pain rated at 1 out of 10 with the use of medications. Provider documentation dated 10-1-15 noted the work status as permanent and stationary. Treatment has included Fentanyl since at least January of 2015, Ativan since at least January of 2015, Zoloft since at least January of 2015, Gabapentin since at least January of 2015, right shoulder magnetic resonance imaging (1-20-15), and Oxycodone. Objective findings dated 10-1-15 were notable for neck range of motion limited, tenderness to the sternocleidomastoid and trapezius with palpable muscle spasms. The treating physician indicates that the urine drug testing result (7-6-15) showed no aberration. The original utilization review (10-10-15) denied a request for Gabapentin 300mg #90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 300mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**Decision rationale:** The claimant has a remote history of a work injury occurring in May 1997 and is being treated for chronic neck pain with upper extremity radicular symptoms. When seen, opioid medications were being weaned. Her Fentanyl dose had been decreased to 75 g but it was not working and she was doubling up on the dose. She reported that she had discontinued use of Trazodone and gabapentin. She was having constant aching pain at the base of the neck radiating into the upper extremities and numbness of her fingers. She had low back pain, which was well-controlled with activity limitation. Physical examination findings included a normal body mass index. There was decreased cervical spine range of motion. There were trigger points and muscle spasms. There was paralumbar and pre-sacral tenderness and pain over the sacrum and coccyx. There was normal lumbar range of motion. The discussion references the claimant as unable to tolerate gabapentin. Inpatient detoxification was being recommended. Authorization is being requested for gabapentin 300 mg #90. Gabapentin has been shown to be effective in the treatment of painful diabetic neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. When used for neuropathic pain, guidelines recommend a dose titration of at least 1200 mg per day. After initiation of treatment, there should be documentation of pain relief and improvement in function. In this case, the claimant has intolerance of this medication at a sub therapeutic dose and is no longer using it. The request is not appropriate or medically necessary.