

<b>Case Number:</b>	CM15-0057454		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	09/11/2012
<b>Decision Date:</b>	05/06/2015	<b>UR Denial Date:</b>	02/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 38 year old male, who sustained an industrial injury on 9/11/12. He reported low back injury. The injured worker was diagnosed as having lumbago. Treatment to date has included oral medications including opioids, TENS unit, topical medications and back brace. (MRI) magnetic resonance imaging of lumbar spine was performed on 3/6/14. Currently, the injured worker complains of mid back, lower back, buttocks and right and left shoulder pain. The injured worker states his pain is not controlled on present regimen. Upon physical exam, decreased range of motion of thoracolumbar spine is noted. The treatment plan consisted of refilling oral medications and use of TENS unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Horizant tab 300mg QD #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain - Horizant (gabapentin enacarbil ER).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Horizant (gabapentin enacarbil ER) <http://www.odg-twc.com/index.html>.

**Decision rationale:** According to ODG guidelines, Horizant; Not recommended as a first-line agent. Horizant (gabapentin enacarbil extended release) is FDA approved for treatment of restless legs syndrome. (FDA, 2011) There is no evidence to support use of Horizant for neuropathic pain conditions or fibromyalgia without a trial of generic gabapentin regular release. See Gabapentin (Neurontin). There are no controlled studies supporting the use of Horizant for neuropathic pain. ODG guidelines do not recommend the use of Horizant for neuropathic pain. Therefore, the request for Horizant is not medically necessary.