

<b>Case Number:</b>	CM13-0024082		
<b>Date Assigned:</b>	11/20/2013	<b>Date of Injury:</b>	03/13/2007
<b>Decision Date:</b>	01/27/2014	<b>UR Denial Date:</b>	08/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/13/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Ohio and Texas. 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 physician 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 claimant is a 37-year-old female with a reported date of injury of 03/13/2007. Mechanism of injury was not specifically described by the records. On 08/16/2007, electrodiagnostic studies were performed and could not confirm lumbar radiculopathy. He was seen in clinic on 01/09/2013 at which time she continued to report pain and gabapentin 300 mg, as well as capsaicin 0.0375%, 10% menthol in 60 grams was prescribed. Urine drug screen obtained on 01/09/2013 and reported on 01/15/2013 found this claimant inconsistent with hydrocodone as none was detected, yet it was prescribed, alprazolam as it was prescribed and none was detected, and duloxetine as it was prescribed and none were detected. Another drug screen reported on 02/23/2013 found her inconsistent for duloxetine as none was detected and it was prescribed and for alprazolam was none was detected and it was prescribed. Hydrocodone was prescribed and it was detected and she was found consistent with her opiates at that time. She returned to clinic on 03/14/2013 at which time she continued to report pain. On 03/25/2013, she was continued on hydrocodone, Colace, and alprazolam for her pain. She returned to clinic with continued reports of pain with pain reported at 4 and she was continued on medications. Diagnosis included chronic back pain and laminectomy syndrome. Plan going forward was to continue with medications in the form of Neurontin and capsaicin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prescription of Neurontin between 7/29/13 and 9/21/13: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neurontin/gabapentin, Anti Epileptic Drugs (AEDs), Page(s): 18,49.

**Decision rationale:** The requested treatment was for prescription of Neurontin between 07/29/2013 and 09/21/2013. MTUS chronic pain guidelines state "Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain... gabapentin monotherapy 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." The records submitted include handwritten notes which are partially illegible due to poor copy quality. However, within the time period in question, between 07/29/2013 and 09/21/2013, the records do not objectively document that this claimant had significant neuropathic pain for which this medication would be supported. The records found her inconsistent with medications on at least 2 different occasions, indicating she did not have any significant pain. While the pain scores were reported, overall efficacy of this medication over time has not been documented by the records. Therefore, this request is not considered medically necessary and is non-certified.

**Two (2) supply of Capsaicin 60gr between 7/29/13 and 9/21/13: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009), Capsacin, topical.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines capsaicin and Topical Analgesics Page(s): 28-29, 111-113.

**Decision rationale:** MTUS chronic pain guidelines state "Recommended only as an option in patients who have not responded or are intolerant to other treatments. Formulations: Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Indications: There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in very high doses. Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. The number needed to treat in musculoskeletal conditions was 8.1. The number needed to treat for neuropathic conditions was 5.7. (Robbins, 2000) (Keitel, 2001) (Mason-BMJ, 2004) The results from this RCT support the beneficial effects of 0.025% capsaicin cream as a first-line therapy for OA pain. (Altman, 1994) Mechanism of action: Capsaicin, which is derived from chili peppers, causes vasodilation, itching, and burning when applied to the skin. These actions are attributed to binding with nociceptors, which causes a period of enhanced sensitivity followed by a refractory period of

reduced sensitivity. Topical capsaicin is superior to placebo in relieving chronic neuropathic and musculoskeletal pain. Capsaicin produces highly selective regional anesthesia by causing degeneration of capsaicin-sensitive nociceptive nerve endings, which can produce significant and long lasting increases in nociceptive thresholds. (Maroon, 2006) Adverse reactions: Local adverse reactions were common (one out of three patients) but seldom serious (burning, stinging, erythema). Coughing has also been reported." Additionally, in regards to topical agents, MTUS chronic pain guidelines state "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended... Recommended only as an option in patients who have not responded or are intolerant to other treatments. Formulations: Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy." While the records indicate this medication, capsaicin, has been recommended, it is not supported by guidelines at this