

Case Number:	CM13-0029731		
Date Assigned:	11/27/2013	Date of Injury:	08/23/2012
Decision Date:	02/20/2014	UR Denial Date:	09/23/2013
Priority:	Standard	Application Received:	09/25/2013

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 Occupational Medicine, and is licensed to practice in California. 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:

Claimant is a 36 year old male with date of injury 8/23/2012. The claimant complains of constant pain rated 5-6/10 in the left buttock that extends into the left ball of the foot. The claimant underwent a lumbar epidural steroid injection in 11/2012, however the low back and left lower extremity symptoms never went away. The claimant complains of depression and frustration. The claimant is not sleeping well and is waking up due to anxiety and pain. Physical examination shows lumbar flexion is 60 degrees, extension is 18 degrees and lateral bending is 25 degrees bilaterally. Tenderness is noted along the paravertebral muscles bilaterally greater on the left side. Severe spasms at the left piriformis region are noted with reproducible pain on deep palpation down the left leg in the sciatic distributions. Mild weakness graded 5-/5 of the foot dorsiflexion is noted. Diagnoses include 1) lesion of ulnar nerve 2) other specified gastritis 3) sciatica 4) medial epicondylitis of elbow 5) lumbar sprain and strain 6) piriformis syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 300mg: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16.

Decision rationale: It is noted in clinical note dated 8/23/2012 that the claimant was taking Gabapentin 300 mg twice daily for neuropathic pain. This request is for Gabapentin 300 mg three times daily. The claimant has complaints of chronic pain with associated neurological deficits on exam. He has been taking this medication chronically. Per Chronic Pain Medical Treatment Guidelines, anti-epilepsy drugs 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. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at post herpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy. (Attal, 2006) The choice of specific agents reviewed below will depend on the balance between effectiveness and adverse reactions." The request for Gabapentin 300 mg is determined to be medically necessary.

Tramadol/APAP 37.5mg: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioid management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80-81.

Decision rationale: It is noted that the claimant was taking Tramadol 50 mg twice daily for severe pain. He was also taking Naprosyn 550 mg twice daily, but was experiencing occasional heartburn after taking NSAIDs. Per Chronic Pain Medical Treatment Guidelines, opioids for chronic pain recommendations include the following: -Neuropathic pain: Opioids have been suggested for neuropathic pain that has not responded to first-line recommendations (antidepressants, anticonvulsants). There are no trials of long-term use. There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant neuropathy. See Opioids for neuropathic pain. - Chronic back pain: Appears to be efficacious but limited for short-term pain relief, and longterm efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a timelimited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. There are three studies comparing Tramadol to placebo that have reported pain relief, but this increase did not necessarily improve function. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (≤70 days). This leads to a concern about confounding issues such as tolerance, opioid-induced hyperalgesia, longrange adverse

effects such as hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect. Long-term, observational studies have found that treatment with opioids tends to provide improvement in function and minimal risk of addiction, but many of these studies include a high dropout rate (56% in a 2004 meta-analysis). There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain. Current studies suggest that the "upper limit of normal" for opioids prior to evaluation with a pain specialist for the need for possible continuation of treatment, escalation of dose, or possible weaning, is in a range from 120-180 mg morphine equivalents a day. There are several proposed guidelines for the use of opioids for chronic non-malignant pain, but these have not been evaluated in clinical