

<b>Case Number:</b>	CM15-0144838		
<b>Date Assigned:</b>	07/30/2015	<b>Date of Injury:</b>	03/23/2006
<b>Decision Date:</b>	08/31/2015	<b>UR Denial Date:</b>	06/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/27/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 previously received the following treatments 8 session of physical therapy, psychiatric services, Diclofenac XR, Omeprazole, TENS (transcutaneous electrical nerve stimulator) unit, left shoulder arthroscopic surgery and cervical spine MRI. The injured worker was diagnosed with anxiety, depression, cervical radicular pain, left shoulder arthroscopic surgery, bilateral carpal tunnel syndrome, low back pain, herniated disc lumbar spine, impingement syndrome of the right shoulder, and cervical spine degenerative disc disease. According to progress note of May 20, 2015, the injured worker's chief complaint was cervical and lumbar radicular pain. The injured worker rated the pain at 6 out of 10, since 2006. The pain radiated into both arms with numbness and tingling. The pain was worse by looking down. The pain was better with Naprosyn. The injure worker was taking Diclofenac in the past which caused gastrointestinal upset. The injured worker was currently taking Omeprazole. The physical exam noted decreased range of motion of the cervical spine flexion of 10 degrees and extension of less than 5 degrees. The sensory exam reported bilateral upper and lower extremities intact to light touch. The treatment plan included prescriptions for Naprosyn and Gabapentin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Naprosyn 500mg 1 tab 2 times daily as needed #60 with 1 refill: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Inflammatory Medications; NSAIDs, GI symptoms & cardiovascular risk Page(s): 22, 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 66-68.

**Decision rationale:** The California chronic pain medical treatment guidelines section on NSAID therapy states: Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. (Roelofs-Cochrane, 2008) See also Anti-inflammatory medications. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. This medication is recommended for the shortest period of time and at the lowest dose possible. The dosing of this medication is within the California MTUS guideline recommendations. The definition of shortest period possible is not clearly defined in the California MTUS. Therefore, the request is medically necessary.

**Gabapentin 300mg 1 tab each night with 1 refill:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs); Gabapentin (Neurontin) Page(s): 49.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines gabapentin Page(s): 18.

**Decision rationale:** The California chronic pain medical treatment guidelines section on Neurontin states: Gabapentin (Neurontin, Gabarone, generic available) has been shown to be effective fortreatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. (Backonja, 2002) (ICSI, 2007) (Knotkova, 2007) (Eisenberg, 2007) (Attal, 2006) This RCT concluded that 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. (Backonja, 1998) It has been given FDA approval for treatment of post-herpetic

neuralgia. The number needed to treat (NNT) for overall neuropathic pain is 4. It has a more favorable side-effect profile than Carbamazepine, with a number needed to harm of 2.5. (Wiffen-Cochrane, 2005) (Zaremba, 2006) Gabapentin in combination with morphine has been studied for treatment of diabetic neuropathy and postherpetic neuralgia. When used in combination the maximum tolerated dosage of both drugs was lower than when each was used as a single agent and better analgesia occurred at lower doses of each. (Gilron-NEJM, 2005) Recommendations involving combination therapy require further study. The patient has the diagnosis of neuropathic pain in the form of radiculopathy. Therefore, the request is necessary and approved.