

<b>Case Number:</b>	CM15-0022503		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	03/27/2009
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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 York, Tennessee  
 Certification(s)/Specialty: Emergency 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 55-year-old male, with a reported date of injury of 03/21/2009. The diagnoses include failed back surgery syndrome, post lumbar decompression and fusion, post lumbar microdiscectomy, lumbar disc protrusion, lumbar neuralgia/neuropathy, sacroiliac joint pain, and myofascial spasm. Treatments have included spinal cord stimulator implant, topical pain medications, oral medications, lumbar decompression and fusion on 05/02/2013, an x-ray of the lumbar spine on 11/07/2011, lumbar microdiscectomy on 03/14/2011, an electrodiagnostic study of the lower extremities on 08/30/2010, an MRI of the lumbar spine on 04/16/2009, a lumbar support brace, and a walker. The primary treating physician's pain management report dated 12/16/2014 indicates that the injured worker complained of chronic low back pain, with radiation to the left lower extremity. The injured worker rated his pain 6 out of 10. It was reported that there was improved back pain and tingling and pain in his lower extremities. A physical examination of the lumbar spine showed right antalgic lean, negative straight leg raise test, reduced lumbar range of motion, decreased deep tendon reflexes at the bilateral patellar and Achilles tendon, absent pathological reflexes, and normal motor strength throughout the bilateral lower extremities. The treating physician requested Neurontin 600mg, transdermal compounded creams, and transportation for doctor's visits. It was noted that medication counseling was discussed, the opiate contract was signed, and CURES and urinalysis was obtained; and the injured worker stated that he could not drive and his wife must take off work to drive him to doctor visits. On 01/15/2015, Utilization Review (UR) denied the request for transportation for doctor's visits, one monthly; Neurontin 600mg #30; and transdermal compounded cream, three

creams 20%, apply two times a day daily. The UR physician noted that there was no documentation of any significant pathological motor weakness, no documentation of true neuropathic pain, and if any compounded medication contains at least one drug or drug class that is not recommended is not recommended. The MTUS Chronic Pain Guidelines and the ACOEM Guidelines were cited.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Transportation for doctor's visits, 1 monthly:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.com; Section: Knee & Leg (Acute & Chronic) (updated 10/27/2014)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines :Knee & Leg, Transportation (to & from appointments)

**Decision rationale:** Transportation is recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. This reference applies to patients with disabilities preventing them from self-transport who are age 55 or older and need a nursing home level of care. In this case the patient does not need a nursing home level of care. Transportation back and forth to appointments is not indicated. The request should not be authorized.

**Neurontin 600mg x 30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain and Interventions and Guidelines Page(s): 18-19.

**Decision rationale:** Neurontin is the anti-epileptic medication gabapentin. Gabapentin 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 and has FDA approval for treatment of post-herpetic neuralgia. Gabapentin appears to be effective in reducing abnormal hypersensitivity, to have anti-anxiety effects, and may be beneficial as a sleep aid. Gabapentin has a favorable side-effect profile, few clinically significant drug-drug interactions and is generally well tolerated; however, common side effects include dizziness, somnolence, confusion, ataxia, peripheral edema, dry mouth, and weight gain. It has been recommended for the treatment of pain from spinal cord injury, fibromyalgia, lumbar spinal stenosis, and chronic regional pain syndrome. Recommended trial period is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. If inadequate control of pain is found, a switch to

another first-line drug is recommended. In this case the patient has been treated with neurontin since at least August 2014 and has not obtained analgesia. Switch to another first-line drug is recommended. The request should not be authorized.

**Transdermal compounded cream: 3 creams; 20%, apply BID daily:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 111-112.

**Decision rationale:** Topical analgesics are recommended for neuropathic pain when anticonvulsants and antidepressants have failed. Compounded topical analgesics are commonly prescribed and there is little to no research to support the use of these compounds. Furthermore, the guidelines state that Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case the medications in the transdermal creams are not documented. There is no documentation that the patient has failed treatment with antidepressants. Indications for treatment with topical analgesics have not been met. The request should not be authorized.