

<b>Case Number:</b>	CM15-0210605		
<b>Date Assigned:</b>	10/29/2015	<b>Date of Injury:</b>	12/20/2010
<b>Decision Date:</b>	12/16/2015	<b>UR Denial Date:</b>	10/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2015

### 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: California, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 58 year old female, who sustained an industrial injury on 12-20-2010. The injured worker is being treated for cervical radiculitis and depression. Treatment to date has included diagnostics, psychological care, acupuncture, physical therapy, pain management, and medications. Per the Initial Evaluation Report dated 9-25-2015, the injured worker reported pain in the neck, upper back, both shoulders, both arms and both hands. The pain is associated with tingling, numbness and weakness in both arms and hands. She rates the severity of the pain as 9 out of 10, with 7 at its best and 10 at its worst. She states her symptoms have been unchanged since the injury. Objective findings of the cervical spine included tenderness to palpation over the bilateral superior trapezius. There is no documentation of improvement in symptoms, increase in activities of daily living or decrease in pain level with the current treatment. The notes from the provider do not document efficacy of the prescribed medications. Work status was temporarily disabled. The plan of care included medication management and authorization was requested on 10-01-2015 for Tramadol ER 150mg #30, Diclofenac XR 100mg #30, Venlafaxine XR 75mg #30, Neurontin 600mg #90 and Prilosec 20mg #60. On 10-07-2015, Utilization Review non-certified the request for Neurontin 600mg #90 and Prilosec 20mg #60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Neurontin 600mg #90:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain - Anti-epilepsy drugs (AEDs) for pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**Decision rationale:** With regard to antiepilepsy drugs, the MTUS CPMTG states "Fibromyalgia: Gabapentin and pregabalin have been found to be safe and efficacious to treat pain and other symptoms. (Arnold, 2007) (Crofford, 2005) Pregabalin is FDA approved for fibromyalgia." Per MTUS CPMTG, "Gabapentin (Neurontin) 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." With regard to medication history, the medical records indicate that the injured worker has been using this medication since at least 4/2015. Per MTUS CPMTG p17, "After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects." Per the documentation submitted for review, it was noted that Gabapentin helps the injured worker sleep and decreases her pain. I respectfully disagree with the UR physician's assertion that the records did not document neuropathic pain. Per progress report dated 9/25/15, the injured worker complained of pain in her neck, upper back, both shoulders, both arms and both hands. The pain is associated with tingling, numbness, and weakness in both arms and hands. She described the pain as sharp, throbbing, dull, aching, pressure like and shooting with pins and needles sensation. The request is medically necessary.

**Prilosec 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an H2-receptor antagonist or a PPI. The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). CPMTG guidelines further specify: "Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.). Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg Omeprazole daily) or

misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardio-protection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)" As there is no documentation of peptic ulcer, GI bleeding or perforation, or cardiovascular disease in the records available for my review, the injured worker's risk for gastrointestinal events is low, as such, request is not medically necessary.