

Case Number:	CM15-0219789		
Date Assigned:	11/12/2015	Date of Injury:	01/22/2001
Decision Date:	12/23/2015	UR Denial Date:	10/21/2015
Priority:	Standard	Application Received:	11/09/2015

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 was a 51 year old male, who sustained an industrial injury on January 22, 2001. The injured worker was undergoing treatment for post laminectomy syndrome lumbar region and intervertebral disc disorder with myelopathy cervicalgia, thoracic or lumbosacral neuritis or radiculitis, displacement of lumbar intervertebral disc and hypertension. According to the progress note of September 29, 2015, the injured worker took blood pressures at home worse was 148 over 93 and typically ran 129 over 80 and was not experiencing any side effects. The physical exam noted the injured worker tended to lean on the right leg. The injured worker had a left sided curvature at the superior thoracic spine. The injured worker had moderate spasms at the mid thoracic spine on the left and severe spasms on the right. There was decreased range of motion in the lumbar spine. According to progress note of October 8, 2015, the injured worker's chief complaint was low back pain with a sensation of a burning pain and pressure which shoots down the legs into the heels and both sides were equally painful. The injured worker had difficulty sitting and driving. The injured worker experienced intense sharp pains at the low back and the back tightens. The injured worker rated the pain at 10 out of 10 3 days a week. While on medications regimen the pain averaged 6-7 out of 10 and gets as low as 5 out of 10 on a good day. The injured worker previously received the following treatments Neurontin 600mg in April 19, 2012; Losartan 25mg #30 was restarted September 29, 2015 for hypertension. The RFA (request for authorization) dated October 12, 2015; the following treatments were requested prescriptions for Losartan 25mg #30 with 5 refills, Neurontin 800mg #90 and H-wave unit to work out back spasms. The UR (utilization review board) denied certification on October 21, 2015; for prescriptions for Losartan 25mg #30 with 5 refills, Neurontin 800mg #90 and an H-wave unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Losartan 25mg, #30 with 5 refills: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Clinical Guidelines Center. Hypertension. Clinical management of primary hypertension in adults. London (UK): National Institute of Health and Clinical Excellence (NICE), 2011 Aug, 36p (Clinical guideline; no. 127).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation PDR, losartan.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The physician desk reference states the requested medication is indicated in the treatment of hypertension. The patient does have these diagnoses due to industrial incident. Therefore the request is medically necessary.

Neurontin 800mg, #90: Overturned

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

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

Decision rationale: The California chronic pain medical treatment guidelines section on Neurontin states: Gabapentin (Neurontin, Gabarone, generic available) 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. (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. (Wiffen2-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 requested medication is a first line agent to treatment neuropathic pain. The patient does have a diagnosis of neuropathic pain in the form of lumbar radiculopathy. Therefore the request is medically necessary.

H-wave unit x1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The California MTUS section on H-wave therapy states: Not recommended as an isolated intervention, but a one-month home-based trial of H-Wave stimulation may be considered as a noninvasive conservative option for diabetic neuropathic pain (Julka, 1998) (Kumar, 1997) (Kumar, 1998), or chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). The patient does not have a documented one-month trial with objective improvement in pain and function as well as the device being used as an adjunct to a program of evidence based functional restoration in the provided clinical documentation for review. Therefore the request is not medically necessary.