

<b>Case Number:</b>	CM15-0034993		
<b>Date Assigned:</b>	03/03/2015	<b>Date of Injury:</b>	04/19/1999
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	01/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/24/2015

### 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: District of Columbia, Virginia  
Certification(s)/Specialty: Internal 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 61 year old female, who sustained an industrial injury on April 19, 1999. The mechanism of injury is unknown. The injured worker was diagnosed as having cervical herniated disc and cervical radiculopathy left side. Treatment to date has included Botox injections, trigger point injections, lumbar epidural injections, massage therapy and medications. On December 17, 2014, the injured worker complained of ongoing pain and discomfort in the neck region and bilateral shoulders. The pain radiates down to the bilateral forearms, hands and fingers. She reported headache, dizziness, loss of memory and difficulty concentrating due to her neck pain. She reported a significant amount of pain and stiffness of the cervical and bilateral upper extremities with performance of activities of daily living. The treatment plan included medications and a toe protector.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Follow up office visit, once per month:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, (ODG), office visit.

**Decision rationale:** Per review of cited guidelines and review of the clinical documentation, the follow up visit would be indicated. Recommended as determined to be medically necessary. Evaluation and management (E & M) outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medications such as opiates or medications such as antibiotics require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG codes for automated approval (CAA), designed to automate claims management decision-making, indicates the number of E & M office visits (codes 99201-992285) reflecting the typical encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation; however, payors should not automatically deny payment for theirs if preauthorization has not been obtained. Note: the high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures but not about the recommended number of E & M office visits. Studies have and are being conducted as to the value of the "virtual visits" compared with inpatient visits; however the value of patient/doctor interventions has not been questioned (Dixon 2008) (Wallace 2004). Further, ODG does provide guidance for therapeutic office visits not included among the E & M codes for example chiropractic manipulation and Physical/Occupational therapy. (Low Back Chapter). Therefore, the request is medically necessary.

**Neurontin 100 mg QTY: 180, 2 tablets 3 times daily:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 16.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 16-19.

**Decision rationale:** This patient had chronic pain issues. This medication would not be indicated for use in this patient, as per cited guidelines. A weaning process should be initiated. Per MTUS: Gabapentin (Neurontin, Gaborone, 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. Mechanism of action: This medication appears to be effective in reducing abnormal hypersensitivity (allodynia and hyperalgesia), to have anti-anxiety effects, and may be beneficial as a sleep aid (Arnold, 2007). Specific pain states: There is limited evidence to show that this medication is effective for postoperative pain, where there is fairly good evidence that the use of gabapentin and gabapentin-like compounds results in decreased opioid consumption. This beneficial effect, which may be related to an anti-anxiety effect, is accompanied by increased sedation and dizziness (Peng, 2007) (Buvanendran, 2007) (Menigaux, 2005) (Pandey, 2005). Spinal cord injury: Recommended as a trial for chronic neuropathic pain that is associated with this condition. (Levendoglu, 2004). CRPS: Recommended as a trial. (Serpell, 2002). Fibromyalgia: Recommended as a trial. (Arnold, 2007). Lumbar spinal stenosis: Recommended as a trial, with statistically significant improvement found in walking distance, pain with movement, and sensory deficit found in a pilot study (Yaksi, 2007). Side-Effect Profile: 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, and dry mouth. (Eisenberg, 2007) (Attal, 2006). Weight gain is also an adverse effect. Dosing Information: Postherpetic neuralgia: Starting regimen of 300 mg once daily on Day 1, then increase to 300 mg twice daily on Day 2; then increase to 300 mg three times daily on Day 3. Dosage may be increased as needed up to a total daily dosage of 1800 mg in three divided doses. Doses above 1800 mg/day have not demonstrated an additional benefit in clinical studies. (Neurontin package insert). Diabetic neuropathy (off-label indication), Gabapentin dosages range from 900 mg to 3600 mg in three divided doses (Backonja, 2002) (Eisenberg, 2007). Gabapentin is 100% renally excreted. Recommended Trial Period: One recommendation for an adequate trial with gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. (Dworkin, 2003) The patient should be asked at each visit as to whether there has been a change in pain or function. Current consensus based treatment algorithms for diabetic neuropathy suggests that if inadequate control of pain is found, a switch to another first-line drug is recommended.

**Naproxen 550 mg QTY: 60, 1 tablet by mouth 2 times daily:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 73.

**Decision rationale:** Per review of the clinical documentation provided, this medication would not be indicated for long term usage. Per MTUS: each patient. Use for moderate pain is off-label.

(Relafen Package Insert), Naproxen (Naprosyn): delayed release (EC-Naprosyn), as Sodium salt (Anaprox), DSA, Aleve (OTC) Generic available; extended-release (Naprelan): 375 mg. Different dose strengths and formulations of the drug are not necessarily bioequivalent. Dosing Information: Osteoarthritis or ankylosing spondylitis: Dividing the daily dose into 3 doses versus 2 doses for immediate-release and delayed-release formulations generally does not affect response. Morning and evening doses do not have to be equal in size. The dose may be increased to 1500 mg/day of Naproxyn for limited periods when a higher level of analgesic/anti-inflammatory activity is required (for up to 6 months). Naprosyn or Naproxyn: 250-500 mg PO twice daily. Anaprox: 275-550 mg PO twice daily. (Total dose may be increased to 1650 mg a day for limited periods). EC-Naprosyn: 375 mg or 500 mg twice daily. The tablet should not be broken, crushed or chewed to maintain integrity of the enteric coating. Naprelan: Two 375 mg tablets (750 mg) PO once daily or two 500 mg tablets (1000 mg) once daily. If required (and a lower dose was tolerated) Naprelan can be increased to 1500 mg once daily for limited periods (when higher analgesia is required). Pain: Naprosyn or Naproxyn: 250-500 mg PO twice daily. The maximum dose on day one should not exceed 1250 mg and 1000 mg on subsequent days. Therefore, the request is not medically necessary.