

Case Number:	CM14-0147440		
Date Assigned:	09/15/2014	Date of Injury:	09/26/2000
Decision Date:	10/15/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	09/10/2014

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 74-year-old male who reported an industrial injury to the back on 9/26/2000, over 14 years ago, attributed to the performance of his usual and customary job duties. The patient complains of chronic low back pain radiating to the left lower extremity. The patient notes that without medications his pain levels characterized as 10/10, however, with medications he reports a level of 8/10. The patient has used the H wave muscle stimulator in the past. The objective findings on examination included antalgic gait, numbness and tingling sensation, limited range of motion of the lumbar spine, tenderness to palpation; spasms at the lumbar paraspinal muscles; positive SLR on the left; decreased motor strength and sensation to the left lower extremity along the L4-L5 dermatome. The treatment plan included the prescription of Neurontin 300 mg #120 with one refill and H wave stimulator pads/supplies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 300mg #120 with 1 refill: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines anti-epilepsy drugs ; specific anti-epilepsy drugs gabapentin Page(s): 16, 18. Decision based on Non-MTUS Citation American College of Occupational and Environmental

Medicine (ACOEM), 2nd Edition, (2004) chronic pain chapter 8/8/2008 page 110: Official Disability Guidelines (ODG) pain chapter-medications for chronic pain

Decision rationale: The treating physician has prescribed gabapentin 300 mg #120 to the patient along with opioids for the treatment of neuropathic pain over a prolonged period of time with the documentation of efficacy noted in the ongoing clinical record. The treating physician has noted decreased pain with the use of gabapentin along with the opioids. There is documentation of functional improvement with the prescription of the gabapentin 300 mg qid. There is documented objective evidence of a nerve impingement radiculopathy and neuropathic pain. The patient is noted to have evidence of radiculopathy with electrodiagnostic studies and the MRI imaging studies. The patient is demonstrated to have neuropathic pain for which Gabapentin has provided functional improvement. The patient is documented on examination to have neuropathic pain for which the patient has received functional benefits from the use of Gabapentin. The prescription of Gabapentin (Neurontin) was demonstrated to have been effective for the patient for the chronic pain issues. The treating physician has provided this medication for the daily management of this patient's chronic pain. The prescription of Gabapentin (Neurontin) is recommended for neuropathic pain; however, the ACOEM Guidelines. Gabapentin or pregabalin is not recommended for treatment of chronic, non-neuropathic pain by the ACOEM Guidelines. The ACOEM Guidelines revised chronic pain chapter states that there is insufficient evidence for the use of Gabapentin or Lyrica for the treatment of axial lower back pain; chronic lower back pain; or chronic lower back pain with radiculopathy. The CA MTUS and the Official Disability Guidelines state that there is insufficient evidence to support the use of Gabapentin or Lyrica for the treatment of chronic axial lower back pain. The prescription of Gabapentin for neuropathic pain was supported with objective findings on physical examination. There was objective evidence that the recommended conservative treatment with the recommended medications have been provided. The use of Gabapentin/Lyrica should be for neuropathic pain. Presently, there is documented objective evidence of neuropathic pain for which the use of Gabapentin is recommended. The patient has demonstrated neuropathic pain secondary to a nerve impingement neuropathy as neuropathic pain for which Gabapentin/Lyrica is recommended. The prescription of Gabapentin is recommended for neuropathic pain and is used to treat postherpetic neuralgia and painful polyneuropathy such as diabetic polyneuropathy. Anti-epilepsy drugs (AEDs) are recommended on a trial basis (Lyrica/gabapentin/pregabalin) as a first-line therapy for painful polyneuropathy such as diabetic polyneuropathy. The updated chapter of the ACOEM Guidelines does not recommend the use of Lyrica or Gabapentin (Neurontin) for the treatment of axial back pain or back pain without radiculopathy. The use of Gabapentin is for neuropathic pain; however, evidence based guidelines do not recommend the prescription of Gabapentin for chronic lower back pain with a subjective or objective radiculopathy and favors alternative treatment. The request for gabapentin 300 mg #120 is demonstrated to be medically necessary.

Unknown H- Wave pads/supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H- Wave Stimulation (HWT).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines H-wave stimulation Page(s): 117-118. Decision based on Non-MTUS Citation American College of Occupational and Environmental

Medicine (ACOEM), 2nd Edition, (2004) Chapter 12 page 300; Chronic pain chapter revised 8/8/08 page 189; Official Disability Guidelines (ODG) Low back chapter--H-wave stimulation devices; Pain chapter H-wave stimulation devices

Decision rationale: Treatment of the back with H-wave is not supported with objective evidence and is not consistent with recommendations of the CA MTUS. The CA MTUS only recommends a 30-day trial of treatment with an H-wave device, "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)." There are no evidence-based guideline recommendations for the H wave muscle stimulator for rehabilitation. The patient's back/neck pain is being evaluated and treated orthopedically. There is no demonstrated medical necessity for the use of the H wave muscle stimulator 18 months status post date of injury. There was no prior use of a TENS unit documented. The provider did not provide subjective/objective evidence to support the medical necessity of the H-wave Unit for the treatment of the patient's pain issues over the recommended participation in a self-directed home exercise program. There is no documentation of failed conservative care; chronic soft tissue inflammation; diabetic neuropathic pain; or participation in HEP. There is no provided functional improvement documented by the requesting provider and there is no objective evidence provided that the use of the H-wave muscle stimulator is medically necessary over a self-directed home exercise program. It is not clear that the requested H-Wave device would be used as an adjunct to a program of functional restoration or that ongoing conservative care. The patient does not meet the criteria recommended by evidence-based guidelines for the use of H-wave devices for the treatment of the back pain. The treatment of chronic back pain with H-wave stimulation is not recommended by the CA MTUS, the ACOEM Guidelines, or the Official Disability Guidelines. There is no objective evidence provided to support the medical necessity of H-wave stimulator over a TENS unit or a self-directed home exercise program. The CA MTUS recommends the H-wave unit for the treatment of diabetic neuropathic pain and not for subacute muscle strains. The ACOEM Guidelines state there is "insufficient evidence" to support the use of the H-wave stimulator for treatment of acute or chronic pain. The requested DME is not directed to a diabetic neuropathy or a chronic soft tissue inflammation as recommended by the CA MTUS or the Official Disability Guidelines. The medical documentation submitted demonstrates that the patient does not meet the criteria recommended by evidence-based guidelines for the use of H-wave devices. The use of the H-wave muscle stimulator unit for treatment of chronic back or pain is not consistent with the applicable guidelines and is not demonstrated to be medically necessary. There is no demonstrated medical necessity for the use of supplies or additional pads for this H wave muscle stimulator.