

Case Number:	CM14-0166123		
Date Assigned:	10/13/2014	Date of Injury:	01/04/2001
Decision Date:	11/13/2014	UR Denial Date:	09/18/2014
Priority:	Standard	Application Received:	10/08/2014

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 Psychiatry and Neurology, has a subspecialty in Geriatric Psychiatry 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:

The injured worker is a 56 year old male whose date of injury is 01/04/2001. He was lifting a steel plate weighing around 300 lbs., resulting in a back injury. He underwent a laminectomy in 2006, then developed severe spinal stenosis requiring L4-5 and L5-S1 decompression and instrumentation in 2008. The patient had tried and failed conservative treatments of medications, injections (lumbar epidural and facet, trigger point), a TENS unit, and physical therapy, in fact feeling that PT may worsen things. He underwent a left total knee arthroscopy in 07/2011, and lumbar fusion at L3-L4 on 03/05/13. Consideration was being given for a spinal cord stimulator. A psychological evaluation on 08/06/14 by [REDACTED] indicated that the patient did not find group behavioral pain management classes in 2012 helpful (he attended three). His Fear Avoidance Beliefs Questionnaire (FABQ) related to work and physical activity was in the very severe range. He was certified for 3 individual psychological visits for pain education and cognitive behavioral treatments at that time. On 08/21/14 in a PR2 by [REDACTED], the patient had low back and increased left knee pain. He complained of numbness and tingling radiating from the knee down to the posterolateral aspect of the left leg to the foot and all toes. With medication his pain was 6/10, without it 10/10. He reported that gabapentin had been minimally effective to date. He had limited range of motion of the lumbar spine due to pain and was positive for lumbar facet syndrome. Left knee active range of motion was normal with tenderness to palpation over the medial joint line and patella. He was diagnosed with post lumbar laminectomy syndrome, lumbar radiculopathy, lumbar facet syndrome, and knee pain. He was seen again on 09/12/14. His pain level was unchanged and his activity level had decreased. In this visit the patient reported that his medications are working well and he was taking them as prescribed. He reported that he still has pain symptoms on a continuous basis but they are alleviated somewhat by current medications. He used 7 per day of Norco when his pain

increased. Medications included Duloxetine, Pennsaid, ibuprofen, gabapentin, famotidine, alprazolam, hydrocodone, DHEA, and carisoprodol.

IMR ISSUES, DECISIONS AND RATIONALES

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

Six (6) individual Psychological Visits for pain education and cognitive behavioral treatments: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398, Chronic Pain Treatment Guidelines Cognitive Behavioral Therapy (CBT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23.

Decision rationale: The patient received modified certification for three individual psychological visits in 08/2014. There was no documentation provided to show whether or not the patient received these services and if he did, if there was any objective functional improvement. As such, at this time this request is noncertified. MTUS recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. See also Multi-disciplinary pain programs. ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain: Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs. See Fear-avoidance beliefs questionnaire (FABQ). Initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone: - Initial trial of 3-4 psychotherapy visits over 2 weeks - With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions).

One (1) prescription of Gabapentin 300mg #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drug (AEDs), Gabapentin (Neurontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Specific Anti-Epilepsy Drugs Page(s): 18-19 of 127.

Decision rationale: Although previously reported as minimally effective, in the most recent report of 09/12/14 the patient indicated that his medications were working well and his pain was somewhat alleviated. He has undergone a number of surgeries and conservative treatments, while continuing to suffer from chronic pain with neuropathy. Gabapentin can be effective for neuropathic pain. As noted in MTUS below, in specific pain states there is fairly good evidence that the use of gabapentin results in decreased opioid consumption. The goal for this patient would be to decrease his pain state with minimal use of opiates, which would also have the effect

of increasing his ability to perform his daily activities. This request is therefore certified. MTUS recommends: 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. (Wiffen-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. 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) 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).