

<b>Case Number:</b>	CM15-0015048		
<b>Date Assigned:</b>	02/03/2015	<b>Date of Injury:</b>	03/29/2005
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	12/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/27/2015

### 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: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

### 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 54 year old female, who sustained an industrial injury on 3/29/2005. On 1/27/15, the injured worker submitted an application for IMR for review of Prospective Usage of Gabapentin 600mg #60, and Prospective Usage of Ibuprofen 800mg #60, and Retrospective Usage of Gabapentin 600mg #60 (Dos 11-26-14) and Retrospective Usage of Ibuprofen 800mg #60 (Dos 11-26-14). The treating provider has reported the injured worker complained of neck pain radiating to right arm pain. The diagnoses have included cervical spine degenerative disc disease with radiculopathy, cervical spine facet arthrosis, status post bilateral carpal tunnel syndrome, right shoulder rotator cuff tear, bilateral shoulder impingement syndrome. Treatment to date has included TENS unit, medication. On 12/31/2015 Utilization Review non-certified Prospective Usage of Gabapentin 600mg #60, and Prospective Usage of Ibuprofen 800mg #60, and Retrospective Usage of Gabapentin 600mg #60 (Dos 11-26-14) and Retrospective Usage of Ibuprofen 800mg #60 (Dos 11-26-14). The MTUS Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Usage of Gabapentin 600mg #60 (Dos 11-26-14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines AEDs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-22. Decision based on Non-MTUS Citation Official Disability Guidelines Chronic Pain, Anti-epilepsy drugs (AEDs) for pain, Gabapentin

**Decision rationale:** The MTUS considers Gabapentin as a first-line treatment for neuropathic pain and effective for the treatment of spinal cord injury, lumbar spinal stenosis, and post op pain. The MTUS also recommends a trial of Gabapentin for complex regional pain syndrome. The ODG states '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. 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.' Additionally, the ODG states that Gabapentin 'has been shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain'. The treating physician does document neuropathic pain of the right upper extremity but the treating physician did not document improved functionality and decreased pain after starting Gabapentin; there is briefly noted in the subjective portion of the 4 nearly identical examination notes which comprise the entirety of the available medical record, that pain improves 50% with medications but there are multiple medications being utilized and no supportive objective findings or imaging/electro-diagnostic reports provided in the record. Further, there is no indication of modification of the dose of Gabapentin being used to improve pain control. Based on the very limited clinical documentation provided, there is no indication that this IW is demonstrating improvement with the use of this medication, if this represents an initial trial or long-term ongoing, or even appropriate objective documentation of the indication for the medication. As such, the request for Gabapentin 600 mg is deemed not medically necessary.

**Retrospective Usage of Ibuprofen 800mg #60 (Dos 11-26-14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ibuprofen, NSAIDs Page(s): 67-72.

**Decision rationale:** The MTUS recommends the use of NSAIDS for the acute exacerbation of pain at the lowest effective dose for the shortest amount of time due to the increased cardiovascular risk, renal, hepatic and GI side effects associated with long term use. MTUS states 'Ibuprofen (Motrin, Advil [otc], generic available): 300, 400, 600, 800 mg. Dosing: Osteoarthritis and off-label for ankylosing spondylitis: 1200 mg to 3200 mg daily. Individual patients may show no better response to 3200 mg as 2400 mg, and sufficient clinical improvement should be observed to offset potential risk of treatment with the increased dose. Higher doses are generally recommended for rheumatoid arthritis: 400-800 mg PO 3-4 times a

day, use the lowest effective dose. Higher doses are usually necessary for osteoarthritis. Doses should not exceed 3200 mg/day. Mild pain to moderate pain: 400 mg PO every 4-6 hours as needed. Doses greater than 400 mg have not provided greater relief of pain. The treating physician in the 4 nearly identical notes that comprise the entirety of the available medical record does not document a decrease in pain or functional improvement from the use of Ibuprofen. There is a mention of a 50% decrease in pain with the use of medications but this is not objectively defined. There is no documentation of specific indication for the use of this medication, and the dose is greater than 400 mg and there is no documentation of the IW being "observed to offset potential risk of treatment with the increased dose" as required by MTUS. As such the request for Ibuprofen 800mg, #60 is deemed not medically necessary.

### **Prospective Usage of Gabapentin 600mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines AEDs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs) Page(s): 16-22. Decision based on Non-MTUS Citation Official Disability Guidelines Chronic Pain, Anti-epilepsy drugs (AEDs) for pain, Gabapentin

**Decision rationale:** The MTUS considers Gabapentin as a first-line treatment for neuropathic pain and effective for the treatment of spinal cord injury, lumbar spinal stenosis, and post op pain. The MTUS also recommends a trial of Gabapentin for complex regional pain syndrome. The ODG states '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. 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.' Additionally, the ODG states that Gabapentin 'has been shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain'. The treating physician does document neuropathic pain of the right upper extremity but the treating physician does not document improved functionality and decreased pain after starting Gabapentin; there is briefly noted in the subjective portion of the 4 nearly identical examination notes which comprise the entirety of the available medical record, that pain improves 50% with medications but there are multiple medications being utilized and no supportive objective findings or imaging/electro-diagnostic reports provided in the record. Further, there is no indication of modification of the dose of Gabapentin being used to improve pain control. Based on the very limited clinical documentation provided, there is no indication that this IW is demonstrating improvement with the use of this medication, if this represents an initial trial or long-term ongoing, or even appropriate objective documentation of the indication for the medication. As such, the request for Gabapentin 600 mg is deemed not medically necessary.

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