

<b>Case Number:</b>	CM15-0125960		
<b>Date Assigned:</b>	07/10/2015	<b>Date of Injury:</b>	05/15/2001
<b>Decision Date:</b>	08/10/2015	<b>UR Denial Date:</b>	06/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2015

### 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: California

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 is a 64 year-old male who sustained an industrial injury on 05/15/01. Initial complaints and diagnoses are not available. Current diagnoses include chronic neck pain and gastroesophageal reflux disease. Diagnostic testing of injury to date is not available. Current treatment includes inversion therapy, Mobic, Gabapentin, and acid reducers. Currently, the injured worker reports Mobic and Gabapentin helps maintain stability in musculoskeletal issues. Requested treatments include Mobic 15 mg, Neurontin 300 mg, and Pepcid 40 mg. The injured worker's disability/work status is not addressed. Date of Utilization Review: 06/09/15.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Mobic 15mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment guidelines comment on the use of NSAIDs, including Mobic, as a treatment modality. In general, NSAIDs are recommended at the lowest dose for the shortest period of time. The specific recommendations are as follows: Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. Back Pain - Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. In this case, the records indicate that Mobic is being used as a long-term treatment for this patient's chronic condition. As noted in the above cited guidelines, only short-term symptomatic use is recommended. It is unclear whether this patient has undergone an adequate trial of a first-line agent such as acetaminophen. For these reasons, the chronic use of Mobic is not supported by the information in the patient's medical records. Therefore, the request is not medically necessary.

**Neurontin 300mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of anti-epilepsy drugs (AEDs), including Neurontin (gabapentin), as a treatment modality. AEDs are used for the treatment of neuropathic pain; e.g. pain caused by nerve root compression. To justify the long-term use of an AED in the treatment of neuropathic pain, the MTUS guidelines indicate that there must be documentation of efficacy. The following are the MTUS recommendations in documenting these treatment outcomes from the use of an AED: Outcome: A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a

"moderate" response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. In this case, there is no documentation provided to determine the effect of Neurontin on this patient's symptoms. It cannot be determined whether the patient has had an adequate trial of Neurontin, used an appropriate dose to address the patient's symptoms or if the use of Neurontin has led to decreased use of other analgesic medications or improved function. For these reasons, the continued use of Neurontin is not supported. Without objective evidence in the medical records to support the impact of Neurontin, it is not considered as a medically necessary treatment.

**Pepcid 40mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & Cardiovascular Risk Page(s): 68-69.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the management of gastrointestinal symptoms in patients on NSAIDs. While this section of the MTUS guidelines focuses on proton pump inhibitors, their findings are applicable as well to the use of H2 blockers, including Pepcid (famotidine). In using medications to protect patient's against adverse GI side effects of NSAIDs, the MTUS guidelines state the following: Clinicians should determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). If patient's deemed to be at low risk for a gastrointestinal side effect, the use of a PPI (or an H2 blocker) is not indicated. In this case, there is insufficient information provided in the medical records to indicate that this patient is at risk for a significant GI side effect. There is no documented evidence of a peptic ulcer, GI bleeding or perforation. The patient is not on high dose/multiple NSAIDs. The patient does not meet the MTUS age criteria. The patient is not taking a corticosteroid or an anticoagulant. Further, as noted in the above request for Mobic (an NSAID), there is insufficient justification for the long-term use of an NSAID. Given that long-term use of an NSAID is not supported and the lack of documentation to indicate the patient is at risk for a significant GI side effect, the use of Pepcid is not considered as medically necessary.