

Case Number:	CM15-0127856		
Date Assigned:	07/14/2015	Date of Injury:	12/03/2013
Decision Date:	08/10/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/02/2015

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: North Carolina

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 female, who sustained an industrial injury on 12/3/13. Initial complaints were not reviewed. The injured worker was diagnosed as having lumbar spondylosis; lumbar degenerative disc disease; lumbar disc disorder; thoracic spine pain; lumbago; sciatica; lumbar radiculopathy; fibromyalgia. Treatment to date has included physical therapy; medications. Diagnostics studies included MRI lumbar spine (2/20/12). Currently, the PR-2 notes dated 6/8/15 indicated the injured worker complains of back pain located in the lower back. She describes the pain as sharp, with numbness, shooting, tingling, constant, throbbing and burning. Her symptoms are reported as ongoing and moderately limit her activities. The frequency is daily and all day and her function is noted as poor. Important triggers include lying down, cold weather, movements, walking, standing, bending, twisting, activity and position change. Pain is alleviated with sleep, heat, rest, medication and physical therapy. The pain radiates down both legs and her complaint is severe pain. She also presents with arm pain bilaterally that radiates to the hands. It is described as numbness, constant tingling, and severe, ongoing daily. The arm pain is alleviated by rest, medications and heat and exacerbated by reaching. Her current medications are listed as Norco, OxyContin, Soma, Xanax, and Robaxin. Physical examination is documented as cervical spine palpation notes tenderness over the spinous processes and tender facet joints. She has cervical muscle tenderness of the bilateral paracervical muscles and bilateral trapezius muscles. The thoracic spine tenderness and bilateral facet loading signs and bilateral paraspinous muscle spasms noted. The lumbar spine inspection notes bilateral facet loading signs and bilateral paraspinous muscle spasms. Left and right sacroiliac joint tenderness is noted. Examination of the bilateral upper extremities notes tenderness overall with normal appearance of shoulders, arms, hands with no crepitus or defects.

Bilateral lower extremities note normal appearance of legs with no crepitus or defects. There is tenderness in the right lower extremity. It appears by this note she received an injection on this date using Ketorolac, lidocaine, magnesium sulfate, Vitamin B12. The provider is requesting authorization of Cyclobenzaprine 10mg for 30 days #120; Gabapentine 600mg for 30 days #90 and Amitriptyline 50mg for 30 days #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 10mg for 30 days #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-65.

Decision rationale: The California chronic pain medical treatment guidelines section on muscle relaxants states: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also, there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) (Chou, 2004) This medication is not intended for long-term use per the California MTUS. The medication has not been prescribed for the flare-up of chronic low back pain. This is not an approved use for the medication. For these reasons, criteria for the use of this medication have not been met. Therefore, the request is not medically necessary.

Gabapentin 600mg for 30 days #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines gabapentin Page(s): 18.

Decision rationale: The California chronic pain medical treatment guidelines section on Neurontin states: 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 2 - 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. The patient has the diagnosis of neuropathic pain in the form of sciatica. Therefore, the request is necessary and approved.

Amitriptyline 50mg for 30 days #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 15.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants Page(s): 15.

Decision rationale: The California MTUS section on antidepressants states: Tricyclic antidepressants are recommended over selective serotonin reuptake inhibitors (SSRIs), unless adverse reactions are a problem. Caution is required because tricyclics have a low threshold for toxicity, and tricyclic antidepressant overdose is a significant cause of fatal drug poisoning due to their cardiovascular and neurological effects. Tricyclic antidepressants have been shown in both a meta-analysis (McQuay, 1996) and a systematic review (Collins, 2000) to be effective, and are considered a first-line treatment for neuropathic pain. (Namaka, 2004) (Dworkin, 2003) (Gilron, 2006) (Wolfe, 2004) (Dworkin, 2007) (Saarto-Cochrane, 2007) This class of medications works in both patients with normal mood and patients with depressed mood when used in treatment for neuropathic pain. (Sindrup, 2005) Indications in controlled trials have shown effectiveness in treating central post-stroke pain, post-herpetic neuralgia (Argoff, 2004), painful diabetic and non-diabetic polyneuropathy, and post-mastectomy pain. Negative results were found for spinal cord pain and phantom-limb pain, but this may have been due to study design. (Finnerup, 2005) Tricyclics have not demonstrated significance in randomized-control trials in treating HIV neuropathy, spinal cord injury, cisplatin neuropathy, neuropathic cancer pain, phantom limb pain or chronic lumbar root pain. (Dworkin, 2007) One review reported the NNT for at least moderate neuropathic pain relief with tricyclics is 3.6 (3-4.5), with the NNT for amitriptyline being 3.1 (2.5-4.2). The NNT for venlafaxine, calculated using 3 studies, was reported to be 3.1 (2.2-5.1). (Saarto-Cochrane, 2007) Another review reported that the NNT for 50% improvement in neuropathic pain was 2 to 3 for tricyclic antidepressants, 4 for venlafaxine, and 7 for SSRIs (Perrot, 2008). The requested medication is a first line treatment choice for neuropathic pain. The patient has neuropathic pain. Therefore, the request is medically necessary.