

<b>Case Number:</b>	CM15-0092293		
<b>Date Assigned:</b>	05/19/2015	<b>Date of Injury:</b>	10/29/2008
<b>Decision Date:</b>	06/18/2015	<b>UR Denial Date:</b>	04/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/14/2015

### 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 48-year-old male, who sustained an industrial injury on October 29, 2008. He reported falling down a ladder with immediate pain in his arms, resulting in bilateral wrist fractures. The injured worker was diagnosed as having carpal tunnel syndrome, other tenosynovitis of hand and wrist, ankyloses of the right hand joint, acute supportive otitis media, and major depressive disorder and anxiety disorder. Treatment to date has included psychotherapy, right hand surgery, x-rays, physical therapy, massage, splinting, MRIs, bracing, and medication. Currently, the injured worker complains of depression, irritability, anxiety with intense pain of the bilateral upper extremities. The Psychological Examination dated February 3, 2015, noted the injured worker reported coping with pain and addressing distraction to assist with symptom alleviation, using social isolation as a means of coping. The injured worker was noted to be making progress. The Primary Treating Physician's report dated March 13, 2015, noted the injured worker was extremely tender to palpation over the volar aspect of the forearm along the flexor tendons, and a positive Durkan's test, which indicated pain and discomfort over the median nerve distribution of the right upper extremity. The treatment plan was noted to include Neurontin, requests for authorization for bilateral wrist splints and evaluation by an orthopedic hand specialist. A subsequent request was made for authorization for Neurontin and twelve individual psychotherapy visits.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Neurontin 600mg, #90 with 2 refills: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin. Decision based on Non-MTUS Citation American Psychiatric Association.

**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. (Wiffen2-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 carpal tunnel syndrome. Therefore, the request is medically necessary and approved.

**12 individual psychotherapy visits: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Psychiatric Association.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines psychological treatment Page(s): 101-102.

**Decision rationale:** The California chronic pain medical treatment guidelines section on psychological treatment states: Recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Psychological treatment incorporated into pain treatment has been found to have a positive short- term effect on pain interference and long-term effect on return to work. The following "stepped- care" approach to pain management that involves psychological intervention has been suggested: Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may

need early psychological intervention. Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point, a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy. Step 3: Pain is sustained in spite of continued therapy (including the above psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also Multi-disciplinary pain programs. See also ODG Cognitive Behavioral Therapy (CBT) Guidelines. (Otis, 2006) (Townsend, 2006) (Kerns, 2005) (Flor, 1992) (Morley, 1999) (Ostelo, 2005) Psychological treatment in particular cognitive behavioral therapy has been found to be particularly effective in the treatment of chronic pain. As this patient has continued ongoing pain, this service is indicated per the California MTUS and thus is medically necessary.