MAXIMUS Federal Services

Case Number:	CM13-0012197		
Date Assigned:	07/25/2014	Date of Injury:	11/28/2007
Decision Date:	12/08/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	08/16/2013

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 patient is a 60-year-old female who has submitted a claim for discogenic cervical disease and cervical joint arthropathy associated with an industrial injury date of 11/28/2007. Medical records from 08/12/2013 to 09/12/2014 were reviewed and showed that patient complained of neck pain graded 7/10 radiating down right shoulder and right scapula. Pain was aggravated with neck movement. Of note, there was no complaint of gastrointestinal disturbances, intolerance to oral pain medications, or insomnia. Physical examination revealed tenderness over right C4-T1 right paracervical spine muscles, decreased cervical ROM, negative Spurling's test, and intact neurologic examination of upper extremities. MRI of the cervical spine dated 08/26/2012 revealed C4 mild spinal canal stenosis, right C4-5 and C5-6 and left C6-7 foraminal narrowing. EMG/NCS of the upper extremities dated 08/14/2012 revealed bilateral demyelinating median and ulnar sensory mononeuropathy. Treatment to date has included physical therapy, Tramadol ER 150mg #30 (DOS: 07/25/2013), Medrox patches #15, Naproxen 550mg #60, Neurontin 600mg #90, Acetadryl 25/500mg #50, and Prilosec 20mg #60. There was no documentation of functional outcome from aforementioned medications. Utilization review dated 08/12/2013 certified the request for Tramadol ER 150mg QTY: 30 because there was documented symptomatic and functional stability from use. Utilization review dated 08/12/2013 denied the request for Medrox patches QTY: 15.00 because the Medrox contained drugs that were not recommended for topical use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Tramadol ER 150mg QTY: 30.00 DOS 07/25/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultram (tramadol) Page(s): 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Page(s): page 78.

Decision rationale: According to page 78 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that ongoing opioid treatment should include monitoring of analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors; these outcomes over time should affect the therapeutic decisions for continuation. In this case,the patient was prescribed Tramadol ER 150mg #30 since 07/25/2013. However, there was no documentation of analgesia or functional improvement with Tramadol use to support treatment extension. Therefore, the Retrospective Tramadol ER 150mg QTY: 30.00 DOS 07/25/2013 is not medically necessary.

Retrospective Medrox patches QTY: 20.00 DOS 07/25/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topicals Topical Analgesics, Page(s): page 105; page 111. Decision based on Non-MTUS Citation ODG) Pain, Salicylates, Topical

Decision rationale: Medrox patches contain: 0.0375% Capsaicin; 5% Menthol; and 5% Methylsalicylate. California MTUS Chronic Pain Medical Treatment Guidelines states that there are no current indications for Capsaicin formulation of 0.0375% as an increase over a 0.025% formulation would provide any further efficacy. ODG Pain Chapter also states that topical pain relievers that contain: Menthol, Methylsalicylate, and Capsaicain, may in rare instances cause serious burns. Page 105 of CA MTUS states that Salicylate topicals are significantly better than placebo in chronic pain. In this case, the patient was prescribed Medrox patches #20 since 07/25/2013. However, the capsaicin content of Medrox patch is not in conjunction with guidelines recommendation. Moreover, there was no documentation of intolerance to oral pain medication to support Medrox patch use. Therefore, the Retrospective Medrox patches QTY: 20.00 DOS 07/25/2013 is not medically necessary.

Retrospective Naproxen 550mg QTY: 60.00 DOS 07/25/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen Page(s): 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Page(s): page 67.

Decision rationale: According to CA MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Continuation or modification of pain management depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities. There is no evidence of long-term effectiveness for pain or function. In this case, the patient was prescribed Naproxen 550mg #60. However, there was no documentation of functional outcome with Naproxen use. Therefore, the request for Retrospective Naproxen 550mg QTY: 60.00 DOS 07/25/2013 is not medically necessary.

Retrospective Neurontin 600mg QTY: 90.00 DOS 07/25/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neurontin (gabapentin) Page(s): 49.

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

Decision rationale: According to pages 16-19 of CA MTUS Chronic Pain Treatment Guidelines, Gabapentin has been considered as a first-line treatment for neuropathic pain. The patient should be asked at each visit as to whether there has been a change in pain or function. 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. In this case, the patient was prescribed Neurontin 600mg #90 (DOS: 07/25/2013). However, there was no documentation of response with Neurontin use per guidelines requirement. Therefore, the request for Retrospective Neurontin 600mg QTY: 90.00 DOS 07/25/2013 is not medically necessary.

Retrospective Acetadryl 25/500mg QTY: 50.00 DOS 07/25/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment for Workers Compensation, 11th Edition, Pain, (updated 06/07/2013) Acetadryl.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Pain, Insomnia treatment

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Pain Section, was used instead. According to the ODG, treatment for insomnia should be based on etiology. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Over the counter medications like sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. In this case, the patient was prescribed Acetadryl 25/500mg since 07/25/2013. However, there was no documentation of insomnia to support Acetadryl use. There is no clear indication for Acetadryl

use at this time. Therefore, the request for Retrospective Acetadryl 25/500mg QTY: 50.00 DOS 07/25/2013 is not medically necessary.

Retrospective Prilosec 20mg QTY: 60.00 DOS 07/25/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk. Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): page 68.

Decision rationale: As stated on page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors: age > 65 years, history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; or on high-dose/multiple NSAIDs. Patients with intermediate risk factors should be started with proton pump inhibitor. In this case, the patient was prescribed Prilosec 20mg #60 since 07/25/2013. However, there was no documentation of gastrointestinal disturbances or intolerance to oral medications. The patient did not meet the criteria for those at risk for gastrointestinal events. Therefore, the request for Retrospective Prilosec 20mg QTY: 60.00 DOS 07/25/2013 is not medically necessary.