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| Case Number: | CM13-0051180 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 12/20/2010 |
| Decision Date: | 08/15/2014 | UR Denial Date: | 10/21/2013 |
| Priority: | Standard | Application Received: | 11/14/2013 |

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 injured worker is a 57 year old male who sustained an injury on 12/20/10 when he fell approximately 12 feet landing on a floor losing consciousness. The injured worker sustained a fracture of the hip. Prior treatment has included an extensive amount of physical therapy as well as aquatic therapy and acupuncture treatment. The injured worker had been followed for ongoing complaints of neck, mid back, and low back pain. Due to ongoing severe pain, the injured worker had limitations in activities and was unable to drive or shop. He had limitations in personal care activities and also reported occasional headaches. Medications did include the use of Methadone 10mg 2 tablets every 12 hours as well as Methadone 10mg 3 times daily. The injured worker was also utilizing Klonopin and Gabapentin. The injured worker did have a noted history for gastritis secondary to medication use and was utilizing Prilosec to address this side effect. He was seen on 10/08/13 for continuing complaints of neck and low back pain that is severe, 10/10 on the visual analogue scale (VAS). The injured worker reported some improvement in pain with the use of Methadone down to 7/10 on the visual analogue scale (VAS). The injured worker had continued difficulty with ambulation as well as performing normal activities of daily living. Physical examination noted limited range of motion in the cervical region. There was tenderness to palpation in the lumbar paraspinal musculature. The injured worker was continued on Gabapentin 600mg for neuropathic pain and Protonix 20mg for gastric upset. The injured worker was also continued on Methadone and Klonopin at this evaluation. Electrodiagnostic studies from 10/24/13 were reported to show no evidence for lower extremity peripheral neuropathy or radiculopathy. Follow up on 10/31/13 noted loss of range of motion in the lumbar spine with tenderness to palpation. There was also limited range of motion in the cervical region. The follow-up on 12/03/13 noted no substantial change in the injured worker's pain scores with or without medications. The injured worker's physical

examination findings were also unchanged. The requested retrospective use of Gabapentin 600mg, quantity 30, retrospective prescription for Protonix 20mg, quantity 60, and future prescribed Gabapentin 600, quantity 30, Protonix 20mg, quantity 60, Methadone 10mg, quantity 60, and Klonopin 1mg, quantity 90 were all denied by utilization review on 10/21/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Gabapentin 600mg #90 with no refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 16-22.

Decision rationale: Based on review of the injured worker's physical examination findings, there is no evidence of an ongoing neuropathic condition that would have supported the use of Gabapentin. The injured worker's most recent electrodiagnostic studies were negative for any evidence of peripheral neuropathy or radiculopathy. Although recommended as a 1st line medication for the treatment of neuropathic symptoms, there is insufficient evidence on physical examination and by diagnostic testing to establish a neuropathic condition that would reasonably support the use of this medication. Therefore, the request is not medically necessary.

Retrospective request for Protonix 20mg #60 with no refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton pump inhibitors.

Decision rationale: The clinical documentation provided for review did note the development of gastric upset as a result of utilizing multiple oral medications. Given this noted side effect from oral medications, the use of a proton pump inhibitor to address continuing gastritis would be supported as medically appropriate and standard of care. Therefore, the request is medically necessary.

Gabapentin 600mg #90 with no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 16-22.

Decision rationale: Based on review of the injured worker's physical examination findings, there is no evidence of an ongoing neuropathic condition that would have supported the use of Gabapentin. The injured worker's most recent electrodiagnostic studies were negative for any evidence of peripheral neuropathy or radiculopathy. Although recommended as a 1st line medication for the treatment of neuropathic symptoms, there is insufficient evidence on physical examination and by diagnostic testing to establish a neuropathic condition that would reasonably support the use of this medication. Therefore, the request is not medically necessary.

Protonix 20mg #60 with no refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton pump inhibitors.

Decision rationale: The clinical documentation provided for review did note the development of gastric upset as a result of utilizing multiple oral medications. Given this noted side effect from oral medications, the use of a proton pump inhibitor to address continuing gastritis would be supported as medically appropriate and standard of care. Therefore, the request is medically necessary.

Methadone 10mg #120 with no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Methadone Page(s): 61.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 88-89.

Decision rationale: The injured worker was utilizing up to 5 tablets of Methadone at 10mg per day which exceeds guideline recommendations regarding the maximum amount of Methadone to be taken in one day. The injured worker is far exceeding the maximum amount of narcotics to be taken in one day set at 100mg morphine equivalent dosage (MED). There is no clear evidence of any substantial functional improvement or pain reduction obtained with the use of Methadone that would have supported its ongoing use. The injured worker's pain scores were minimally improved and the injured worker had no evidence of functional improvement. Therefore, the request is not medically necessary.

Klonopin 1mg #90 with no refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Benzodiazepines Page(s): 24.

Decision rationale: The chronic use of benzodiazepines is not recommended by current evidence based guidelines as there is no evidence in the clinical literature to support the efficacy of their extended use. The current clinical literature recommends short term use of benzodiazepines only due to the high risks for dependency and abuse for this class of medication. The clinical documentation provided for review does not specifically demonstrate any substantial functional improvement with the use of this medication that would support its ongoing use. Therefore, the request is not medically necessary.