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| Case Number: | CM14-0108792 | | |
| Date Assigned: | 08/01/2014 | Date of Injury: | 12/30/2003 |
| Decision Date: | 09/24/2014 | UR Denial Date: | 07/09/2014 |
| Priority: | Standard | Application Received: | 07/14/2014 |

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 Emergency and Internal Medicine and is licensed to practice in Florida. 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:

This patient is a 57 year-old with a date of injury of 12/30/03. A progress report associated with the request for services, dated 06/11/14, identified subjective complaints of neck and low back pain. Objective findings included tenderness to palpation of the lumbar spine. Diagnoses included lumbar disc disease with radiculopathy; previous L1 burst fracture, possible RSD of the lower extremity; and peripheral polyneuropathy. Treatment has included a lumbar fusion in 2004 and a cervical fusion in 2010. Medications reduce the pain from 8/10 to 4/10, and improve function including the activities of daily living as well as exercise and walking. The medication effects last for 4 hours and there have been no side effects. A Utilization Review determination was rendered on 07/09/14 recommending non-certification of retrospective Neurontin 800 mg, #180 (dispensed on 06/11/2014); retrospective request for Norco 10/325 mg, #360 (dispensed on 06/11/2014); and Amitriptyline 50mg, #60 with three refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitriptyline 50mg, #60 with three refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13-16.

Decision rationale: Chronic Pain Guidelines note that some antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. The tricyclic agents are generally considered first-line unless they are ineffective, poorly tolerated or contraindicated. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in the use of other analgesics, sleep quality and duration as well as a psychological assessment. The optimal duration of therapy is not known. The Guidelines recommend that assessment of treatment efficacy begin at one week with a recommended trial of at least 4 weeks. For neuropathic pain, tricyclics agents are recommended as first-line. Antidepressants are listed as an option in depressed patients with non-neuropathic pain, but effectiveness is limited. The guidelines note that non-neuropathic pain is generally treated with analgesics and anti-inflammatories. Additionally, the guidelines state that in low back pain tricyclic antidepressants have demonstrated a small to moderate effect on chronic low back pain (short-term pain relief), but the effect on function is unclear. No studies have specifically studied the use of antidepressants to treat pain from osteoarthritis. The guidelines do note that in depressed patients with osteoarthritis, improving depression symptoms was found to decrease pain and improve functional status. Based on the documentation of functional improvement with the chronic use of the Amitriptyline, the request is medically necessary.

Retrospective request for Norco 10/325 mg, #360 (dispensed on 06/11/2014): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308, Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids for Chronic Pain.

Decision rationale: Norco 10/325 is a combination drug containing acetaminophen and the opioid hydrocodone. The MTUS Chronic Pain Guidelines related to on-going treatment of opioids state that there should be documentation and ongoing review of pain relief, functional status, appropriate use, and side effects. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid state that there should be documentation and ongoing review of pain relief, functional status, appropriate use, and side effects. The guidelines note that a recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of the key outcome goals including pain relief, improved quality of life, and/or improved functional capacity. The Chronic Pain Guidelines also state that with chronic low back pain, opioid therapy appears to be efficacious, but limited for short-term pain relief, and long-term efficacy is unclear. Guidelines further state that opioid therapy is not recommended for the low back beyond 2 weeks. The Official Disability Guidelines state that while long-term opioid therapy may benefit some patients with severe suffering, it is not generally effective in achieving the original goals of complete pain relief and functional restoration. In this case, the documentation submitted included a number of the elements listed above, including the level of functional improvement afforded by the chronic opioid therapy. Therefore, the request is medically necessary.

Retrospective Neurontin 800 mg, #180 (dispensed on 06/11/2014): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 16-21; 49.

Decision rationale: Gabapentin (Neurontin) is an anti-seizure agent. Chronic Pain Guidelines note that this class of agents is recommended for neuropathic pain, but there are few randomized trials directed at central pain and none for painful radiculopathy. Guidelines further state that a recent review has indicated that there is insufficient evidence to recommend for or against antiepileptic drugs for axial low back pain. In this case, there is documentation for a possible neuropathic component to the pain. Also, there is documentation of functional improvement from the Neurontin. Return to work is not the sole determinate of functional improvement. As such, the request is medically necessary.