

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0135877 | | |
| Date Assigned: | 09/03/2014 | Date of Injury: | 06/17/1996 |
| Decision Date: | 10/03/2014 | UR Denial Date: | 08/19/2014 |
| Priority: | Standard | Application Received: | 08/25/2014 |

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 Family Medicine and is licensed to practice in California. 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:

Patient is a 58-year-old female who has submitted a claim for cervical spine discopathy, lumbar spine discopathy, somatoform discopathy, and knee osteoarthritis associated with an industrial injury date of 05/17/1996. Medical records from 2014 were reviewed. Patient complained of neck pain radiating to bilateral upper extremities, associated with numbness, muscle spasm, and headaches. Patient likewise reported low back pain radiating to bilateral lower extremities, aggravated by activity and walking. Pain was rated 10/10 in severity, with or without medications. Physical examination of the cervical and lumbar spine showed tenderness and limited motion. Paralumbar muscles were positive for tenderness and muscle spasm. Weakness of bilateral lower extremities was noted. Achilles reflexes were decreased bilaterally. Patellar reflexes were absent. Straight leg raise was positive bilaterally. Sensation was diminished at bilateral upper extremities. Urine drug screen from 03/13/2014 and 06/10/2014 showed inconsistent results with prescribed medications. Treatment to date has included cervical epidural steroid injection, acupuncture, trigger point injection, and medications such as Condrolite, Topiramate (for headache), Prilosec, gabapentin, Norco, and tizanidine (all since January 2014). Utilization review from 08/19/2014 denied the requests for Condrolite 500/200/150/Mg, #90 and Gabapentin 600mg, #90 because patient still had enough supply of Condrolite based on a previous utilization review; modified the request for Hydrocodone/APAP 10/325 MG #120 into #60 for the purpose of weaning due to lack of documentation of objective improvement in pain or function; denied Topiramate 200 MG #60 because there was no evidence of failure of anticonvulsants therapy; denied Zanaflex 4 MG #60 because of no documentation of acute exacerbation of low back pain; and denied Prilosec 20 MG #60 because of no documented gastrointestinal issues.

IMR ISSUES, DECISIONS AND RATIONALES

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

Condrolite 500/200/150/Mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Meds for Chronic Pain Glucosamine (and Chondroitin Sulfate).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine and Chondroitin Sulfate Page(s): 50. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA Methylsulfonylmethane.

Decision rationale: Condrolite is a medical supplement consisting of glucosamine sulfate 500mg, chondroitin sulfate 200mg, and MSM 150mg. CA MTUS Chronic Pain Medical Treatment Guidelines page 50 states that Glucosamine and Chondroitin Sulfate are recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Methylsulfonylmethane (MSM) is not FDA approved. In this case, patient has been on Condrolite since January 2014. MRI of the left knee from 05/30/2009 demonstrated mild medial tibiofemoral compartment osteoarthritis. However, recent progress reports failed to provide evidence of knee pain. Patient has no osteoarthritis of painful body parts that would necessitate use of this supplement. There is no clear rationale for the use of this supplement. Therefore, the request for CONDROLITE 500/200/150MG #90 is not medically necessary.

Gabapentin 600mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-17.

Decision rationale: As stated on pages 16 - 17 of CA MTUS Chronic Pain Medical Treatment Guidelines, antidepressants, such as pregabalin and gabapentin, are recommended as a first line option for neuropathic pain, i.e., painful polyneuropathy. In this case, the patient has been on gabapentin as early as January 2014. Patient's manifestation of chronic neck pain radiating to bilateral upper extremities associated with numbness, is consistent with neuropathic pain. However, there is no documentation concerning pain relief and functional improvement derived from its use. Therefore, the request for GABAPENTIN 600mg, #90 is not medically necessary.

Hydrocodone/APAP 10/325 MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

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

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on hydrocodone/APAP since January 2014. However, the medical records do not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. Moreover, urine drug screens from 03/13/2014 and 06/10/2014 showed inconsistent results with prescribed medications. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request for hydrocodone/APAP 10/325 mg, #120 is not medically necessary.

Topiramate 200 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topiramate.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 16-22.

Decision rationale: As stated on pages 16-22 of the California MTUS Chronic Pain Medical Treatment Guidelines, anti-epilepsy drugs are recommended for neuropathic pain. Outcomes with at least 50% reduction of pain are considered good responses. In this case, patient has been on topiramate since January 2014. Medical records submitted that it was prescribed for headaches. However, there is no documentation concerning pain relief and functional improvement derived from its use. Therefore, the request for TOPAMAX 200MG #60 is not medically necessary.

Zanaflex 4 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Page(s): 63.

Decision rationale: According to page 63 of the CA MTUS Chronic Pain Medical Treatment Guidelines, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, the patient has been on Zanaflex since January 2014. However, there is no documentation concerning pain relief and functional improvement derived from its use. Although the most recent physical examination showed evidence of muscle spasm, long-term use of muscle relaxant was not recommended. Therefore, the request for Zanaflex 4mg, #60 is not medically necessary.

Prilosec 20 MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms, and Cardiovascular Risk Page(s): 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 prescribed proton pump inhibitors (PPI). In this case, patient has been on Prilosec since January 2014. However, there was no subjective report of heartburn, epigastric burning sensation or any other gastrointestinal symptoms that may corroborate the necessity of this medication. Furthermore, patient did not meet any of the aforementioned risk factors. The guideline criteria were not met. Therefore, the request for Prilosec 20mg, #60 is not medically necessary.