

Case Number:	CM14-0147428		
Date Assigned:	09/18/2014	Date of Injury:	09/25/2006
Decision Date:	12/11/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	09/10/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. The expert reviewer is Board Certified in Occupational Medicine, has a subspecialty in Family Practice and is licensed to practice in Ohio. 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 64 year old with a date of injury of 9-25-2006 that was essentially a slip and fall. His subsequent medical/surgical history is complex. He subsequently developed neck pain, low back pain with radicular symptoms, bilateral shoulder pain, pain and numbness in the wrists and thumbs. He has had several surgeries including a C4-C7 fusion, a posterior fusion from L4-S1, and later hardware removal from L4-L5, exploration of the fusion, complete L5 laminectomy, and neurolysis of the L5 nerve root. Currently, he is said to have improved low back pain but worsened right lower extremity pain. The physical exam reveals tenderness to palpation of the lumbar spinous processes, the right sacroiliac joint, diminished lumbar range of motion, diminished sensation to both thumbs, and an absent left Achilles's reflex. There is a positive right sided Faber's test, and a positive Tinnel's sign of the left elbow. The diagnoses include residual lumbar radiculopathy, left elbow neuritis, mild bilateral carpal tunnel syndrome, pseudoarthrosis of the lower lumbar spine, and rotator cuff tendonitis. The treating physician reduced the total daily dose of Hydrocodone from 20 mg a day to 5 mg a day and added 150 mg of Tramadol on 7-18-2014. The requests for Tramadol, Neurontin, Omeprazole, and Hydrocodone 2.5/325 mg twice a day have been denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 2.5/325 mg 1 tablet every 4-6 hours as needed for pain # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49, 68, 79.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Those being treated chronically with opioids for pain are required by the cited guidelines to have ongoing monitoring of pain relief, functionality, medication side effects, and any aberrant drug taking behavior. Typical questions regarding opioids include pain levels with and without the medication, average pain levels, best and worst pain levels, time for the opioid to become effective and duration of pain relief. Opioids may be continued if there is improvement in pain and functionality. The previous reviewer denied the request for Norco 2.5/325 mg twice a day because the provided notes do not provide this information. The recent dose change actually maintained the morphine equivalency of 20 milligrams per day, and even though the Norco was reduced, the addition of tramadol essentially maintained the same levels of opioids. There is no question that the injured worker has several painful conditions with different pain mechanisms, however the guidelines demand that appropriate documentation be provided regarding improvements in pain and functionality if the opioids are to be continued at current levels. The medical necessity for Norco 2.5/325 mg 1 tablet every 4-6 hours as needed for pain # 60 has not been established from a documentation perspective.

Gabapentin 300 mg 1 tablet three times a day, # 90: Overturned

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

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

Decision rationale: Anti-epilepsy drugs like Neurontin (Gabapentin) are recommended for neuropathic pain (pain due to nerve damage). There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy. The choice of specific agents reviewed below will depend on the balance between effectiveness and adverse reactions. 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. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. In this instance, the first prescription date for the Gabapentin appears to be from 7-18-2014 with a subsequent denial. There does not appear to have been time for an adequate trial to say if the Gabapentin was helping or not. There

certainly seems to be several etiologies for neuropathic pain in this case. Therefore, Gabapentin 300 mg 1 tablet three times a day, # 90 was medically necessary.

Omeprazole DR 20 mg 1 tablet every day # 30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk

Decision rationale: The medical justification for the use of Omeprazole in this case comes not from the text of any progress note, but from an appeal letter. The justification was stated as being prophylaxis of Gastrointestinal (GI) events as a consequence of treatment with Tramadol and Norco. The Official Disability Guidelines state that proton pump inhibitors like Omeprazole may be justified for use prophylactically if the patient is taking a NSAID and has one of the following risk factors for GI events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). A history of ulcer complications is the most important predictor of future ulcer complications associated with NSAID use. In this instance, the injured worker would appear not to be taking an NSAID and otherwise not have risk factors for GI events. He does have a history of colon surgery previously for reasons unknown. No abdominal pain is noted in the treating providers' notes. As such, Omeprazole DR 20 mg 1 tablet every day # 30 was not medically necessary.

Tramadol ER 150 mg 1 tablet at the time every day # 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Those being treated chronically with opioids for pain are required by the cited guidelines to have ongoing monitoring of pain relief, functionality, medication side effects, and any aberrant drug taking behavior. Typical questions regarding opioids include pain levels with and without the medication, average pain levels, best and worst pain levels, time for the opioid to become effective and duration of pain relief. Opioids may be continued if there is improvement in pain and functionality. The previous reviewer denied the request for Norco 2.5/325 mg twice a day because the provided notes do not provide this information. The recent dose change actually maintained the morphine equivalency of 20 milligrams per day, and even though the Norco was reduced, the addition of tramadol essentially maintained the same levels of opioids. There is no question that the injured worker has several painful conditions with different pain mechanisms, however the guidelines demand that appropriate documentation be provided regarding improvements in pain and functionality if the opioids are to be continued at current

levels. The medical necessity for Tramadol ER 150 mg 1 tablet at the time every day # 30 has not been established from a documentation perspective.