

Case Number:	CM14-0155611		
Date Assigned:	09/25/2014	Date of Injury:	04/21/2008
Decision Date:	10/27/2014	UR Denial Date:	09/18/2014
Priority:	Standard	Application Received:	09/23/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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:

The patient is a 40-year-old male with a date of injury of 04/21/2008. The listed diagnoses per [REDACTED] are: 1. Sprain/strain of lumbar region. 2. Headache. 3. Major depression, recurrent episodes. 4. Pain, psychogenic NEC. 5. Agoraphobia with panic attacks. 6. Chronic pain. 7. Long-term use of medications. Treatment reports from 2/7/14-7/8/14 were reviewed. According to progress report 06/24/2014, the patient presents with chronic back, hip, and shoulder pain. He also complains of anxiety and depression. The patient continues to have migraine headaches almost on a daily basis. Low back pain radiates down the left lower extremity with associated numbness and tingling. The patient reports pain as 7/10 on a VAS today without medication. He notes that medication do help improve his pain by about 50%. The patient is tolerating the medications well without side effects. The patient's medication regimen includes capsaicin cream, ketamine cream, hydrocodone/APAP 10/325 mg, pantoprazole 20 mg, mirtazapine 15 mg, Sumatriptan 25 mg, gabapentin 600 mg, Seroquel 25 mg, tramadol/APAP 37.5/325 mg, orphenadrine 100 mg, and naratriptan 1 mg. Utilization review denied the request on 09/18/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketamine 5% cream 60mg DOS: 6/24/14: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: This patient presents with chronic back, hip, and shoulder pain. The treater is requesting ketamine 5% cream 60 mg. Utilization review denied the request stating that, "there is no documentation of the claimant's intolerance of these or similar medications to be taken on an oral basis." The MTUS guidelines have the following regarding topical creams (p111, chronic pain section): For Ketamine topical, it is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. In this case, the treater states that patient has 50% improvement in pain with current medications, which includes Ketamine topical cream. Given the patient's continued radicular symptoms and the efficacy of this cream, the request is medically necessary.

Tramadol/APAP 37.5/325mg #90 DOS: 6/24/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Analgesics Page(s): 93-94, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS; CRITERIA FOR USE OF OPIOIDS Page(s): 88-89; 76-78.

Decision rationale: This patient presents with chronic back, hip, and shoulder pain. The treater is requesting a refill of tramadol/APAP 37.5/325 #90. The patient is TTD and not working. The MTUS guidelines pg 76-78, criteria for initiating opioids recommends that reasonable alternatives have been tried, consider patient's likelihood of improvement, likelihood of abuse, etc. For opiate management, MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior). Review of the medical file indicates the patient has been prescribed tramadol since at least 02/07/2014. It was noted patient continues to utilize both Tramadol and hydrocodone for pain control which has been effective. Report 05/27/2014 states the patient has difficulty sleeping without his medications. Report 02/07/2014 states that the patient remains at a 6/10 on a VAS with medications. Without medication, pain level rises to a 10/10. The patient was reported to be able to walk, sit, and stand for longer period of time with medications. In this case, the treater indicates efficacy of this medication by providing a pain scale and specific functional improvement, but there is no urine drug screen to monitor medication. MTUS requires not only analgesia and discussion of functional changes, but urine drug screens to monitor medications. There are no discussions regarding side effects or aberrant drug behavior. No outcome measures are discussed either as required by MTUS. Given lack of sufficient documentation for opiate management, the request is not medically necessary.

Orphenadrine-Norflex ER 100mg #90 DOS: 6/24/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Opioids Page(s): 64-66, 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64.

Decision rationale: This patient presents with chronic back, hip, and shoulder pain. The treater is requesting a refill of orphenadrine ER 100 mg #90. Review of the medical file indicates the patient has been taking this medication since 02/07/2014. The MTUS Guidelines do not recommend long-term use of muscle relaxants and recommend using it for 3 to 4 days for acute spasm and no more than 2 to 3 weeks. This medication has been prescribed for long term use, the request is not medically necessary.

Hydrocodnebit/APAP 10/325mg #90 DOS: 6/24/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS; CRITERIA FOR USE OF OPIOIDS Page(s): 88-89; 76-78.

Decision rationale: This patient presents with chronic back, hip, and shoulder pain. The treater is requesting a refill of hydrocodone/APAP 10/325 mg #90. MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Review of the medical file indicates the patient has been prescribed Tramadol since at least 02/07/2014. It was noted patient continues to utilize both Tramadol and Hydrocodone for pain control which has been effective. Report 05/27/2014 states the patient has difficulty sleeping without his medications. Report 02/07/2014 states that the patient remains at a 6/10 on a VAS with medications. Without medication, pain level rises to a 10/10. The patient was reported to be able to walk, sit, and stand for longer period of time with medications. In this case, the treater indicates efficacy of this medication by providing a pain scale and specific functional improvement, but there is no urine drug screen to monitor medication. MTUS requires not only analgesia and discussion of functional changes, but urine drug screens to monitor medications. Given lack of sufficient documentation for opiate management, the request is not medically necessary.

Pantopazole-Protonix 20mg DOS: 6/24/14: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) chapter, Proton pump inhibitors (PPIs)

Decision rationale: This patient presents with chronic back, hip, and shoulder pain. The treater is requesting Protonix 20 mg. Utilization review denied the request stating, "ODG notes that a trial of Prilosec or Prevacid is recommended as a first-line of treatment. Other PPI such as Protonix... are considered second-line therapy." The MTUS Guidelines page 68 and 69 states that Omeprazole is recommended with precaution for patients at risk for gastrointestinal events: (1) Age is greater than 65, (2) History of peptic ulcer disease and GI bleeding or perforation, (3) Concurrent use of ASA or corticosteroid and/or anticoagulant, (4) High dose/multiple NSAID. Review of the medical file indicates the patient has stomach problems due to GERD. In this case, review of the medical file indicates that the patient has gastroesophageal reflux. The treater reports continued GI symptoms including heartburn, nausea, and abdominal pain. Furthermore, medical records indicate the patient has been taking NSAID on a long-term basis. Given such, Protonix is medically necessary, the request is medically necessary. .

Quetiapine Femarate-Seroquel 25mg #60 DOS: 6/24/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress chapter, Insomnia treatment

Decision rationale: This patient presents with chronic back, hip, and shoulder pain. The treater is requesting a refill of Seroquel 25 mg #60 to be taken at bedtime for patient's depression. The ACOEM and MTUS do not discuss Seroquel specifically. Regarding insomnia, ODG does not specifically discuss Seroquel but states "Sedating antidepressants (e.g., amitriptyline, Trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia (Buscemi, 2007) (Morin, 2007), but they may be an option in patients with coexisting depression." For depression treatments, ODG states, "Adding an atypical antipsychotic to an antidepressant provides limited improvement in depressive symptoms in adults, new research suggests. The meta-analysis also shows that the benefits of antipsychotics in terms of quality of life and improved functioning are small to nonexistent, and there is abundant evidence of potential treatment-related harm." Review of the medical file indicates the patient has been utilizing this medication since at least 02/07/2014. Report 02/07/2014 notes, "He is currently taking Seroquel 25 to 50 mg at bedtime, which he says does help with his sleep." In this case, ODG does not support this medication for insomnia nor depression. The request is not medically necessary.