

Case Number:	CM14-0042109		
Date Assigned:	06/30/2014	Date of Injury:	04/07/2010
Decision Date:	12/24/2014	UR Denial Date:	03/31/2014
Priority:	Standard	Application Received:	04/08/2014

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 North Carolina. 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 51 year old female has reported neck pain that radiates from the neck down into both arms, and backache, stemming from a work related injury on 4/7/2010. Associated complaints include poor sleep and activity levels. Diagnoses include cervical radiculopathy, post cervical laminectomy syndrome, and muscle spasms. Treatments have included consultations, diagnostic studies, chiropractic treatments, physical therapy, acupuncture, trigger point injections, biofeedback, surgery (11/26/2011), and medication management. Progress notes dated 2/10/2014 show continued complaints of radiating neck pain, rated 9/10, objective assessment findings note limited cervical neck range of motion restricted by pain, and without radicular symptoms. Medications are noted to include Amlodipine Besylate, Omeprazole Dr, Plaquenil, Tylenol EX, and Valium; it was stated she was not on any pain medications at that time. The urine drug screen, same date, detected positive findings for medications, including pain medication, not currently prescribed for this injured worker (IW); and was addressed with this IW. Progress notes, dated 3/17/2014, note no significant changes in her complaints of continued radiating neck pain. There was no significant change in objective findings that included muscle spasms. The current medication regimen included Percocet, Gabapentin, Valium and Tylenol. The reported qualified medical evaluation, done 3/10/2014, recommended an MRI of the lumbar spine; also the cervical spine surgeon reviewed new x-rays and ordered no further follow-up. The plan included a re-request for left cervical paraspinal trigger point injections to address spasm and trigger points, and continuation of Percocet for pain and Gabapentin for her neuropathic pain and to help her sleep, also, samples of Senokot S were given to help with constipation. On 3/31/2014, Utilization Review non-certified the request for Gabapentin 300mg, 2 tabs at bed time, #60 and Percocet 10/325mg, up to 3 tabs a day as needed for pain, #90 as not being medically necessary. Documentation for lack of functional improvement or measurable analgesic benefit, as

recommended by MTUS Guidelines was cited; and a tapering, not an abrupt cessation, was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 300 mg capsule #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18.

Decision rationale: The California chronic pain medical treatment guidelines section on Gabapentin states: Gabapentin (Neurontin, Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. This RCT concluded that gabapentin monotherapy appears to be efficacious for the treatment of pain and sleep interference associated with diabetic peripheral neuropathy and exhibits positive effects on mood and quality of life. It has been given FDA approval for treatment of post-herpetic neuralgia. The number needed to treat (NNT) for overall neuropathic pain is 4. It has a more favorable side-effect profile than Carbamazepine, with a number needed to harm of 2.5. Gabapentin in combination with morphine has been studied for treatment of diabetic neuropathy and postherpetic neuralgia. When used in combination the maximum tolerated dosage of both drugs was lower than when each was used as a single agent and better analgesia occurred at lower doses of each. Recommendations involving combination therapy require further study. Mechanism of action: This medication appears to be effective in reducing abnormal hypersensitivity (allodynia and hyperalgesia), to have anti-anxiety effects, and may be beneficial as a sleep aid. Specific pain states: There is limited evidence to show that this medication is effective for postoperative pain, where there is fairly good evidence that the use of gabapentin and gabapentin-like compounds results in decreased opioid consumption. This beneficial effect, which may be related to an anti-anxiety effect, is accompanied by increased sedation and dizziness. The requested medication is a first line choice in the treatment of neuropathic pain per the California MTUS. The patient per the provided documentation has the diagnosis of cervical radiculopathy and complaint of pain that radiates from the neck down both arms. The patient has no contraindications to taking this medication. Therefore the request is medically necessary.

Percocet 10/325 mg tablets #90: 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): 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication 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; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking 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. (Passik, 2000)(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management.(e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control.(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion).(g) Continuing review of overall situation with regard to nonopioid means of pain control.(h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids (a) If the patient has returned to work (b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004).