MAXIMUS Federal Services

Case Number:	CM14-0057188		
Date Assigned:	07/09/2014	Date of Injury:	02/21/1980
Decision Date:	08/18/2014	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/28/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 66-year-old woman who sustained a work-related injury on February 21, 1980. She subsequently developed chronic low back pain. In a report dated March 13, 2104, the patient complained of lower back pain that radiated down to the left leg and into the right hip. The pain was rated at 7/10 at worse and 2/10 at least. It was noted that she underwent laminectomy L4-L5 in 1973; back fusion at L4-L5 and L5-S1 in 1980; had repeat surgeries and spinal fusion in October 1981 and ended up having 4 surgeries with ultimate fusion instrumentation of hardware, L3-L4, L4-L5, and L5-S1 on January 7, 2003. It was also noted that she was initially evaluated in 2005 and subsequently underwent medication management as well as epidural steroid injections via caudal approach as well as transforaminal approach, which she did reasonably well. Her last epidural steroid injection resulted in spinal block. Past medication included: Trileptal, ibuprofen, Naprosyn, Celebrex, Valium, Darvocet, Codeine, and Percocet. Past teatments included: physical therapy, injections, massage therapy, surgery, psychotherapy, chiropractic, acupuncture, and sacroiliac joint injections. Past procedures included: bilateral sacroiliac joint injections on November 28, 2012 with 90% relief of lumbosacral pain bilaterally; last epidural steroid injection on December 18, 2009 with numbness and weakness from her waist down, incontinent of urine and the feeling returned to her leg immediately after the procedure for about 18 hours but continued to have increased pain in her leg. It was mentioned that an MRI of the lumbar spine on September 17, 2002 showed disc desiccation and bulging at L3-L4 with facet joint hypertrophy; however, the patient underwent fusion surgery since this MRI and also had previous laminectomy defect at L4-L5 narrowing of the disc spaces. There were postoperative changes at L5-S1. No evidence of disc protrusion. An EMG study on May 25, 2004 indicated right S1 radiculopathy, possible lumbar plexopathy. Degenerative potentials indicated multiple nerve root involvement indicative of spinal or foraminal stenosis. It was

indicated that the patient was compliant with narcotic pain management. Current medications included: Kadian extended release, Victoza, Cymbalta, Advair Diskus, Vicodin, Oxybutynin, Amitriptyline HCL, gabapentin, and hydrocodone-acetaminophen. Physical examination of the lumbar spine revealed mild discomfort and depression; bilateral nonpitting edema of the bilateral lower extremities; flattening of normal lumbar lordosis was noted; noted scar of previous lumbar surgery; absent trigger points and muscle spasms; positive straight leg raise on the right for lower back pain and radicular pain; diffusely tender facet tenderness bilaterally; negative facet loading test; tenderness at the sacroiliac joint bilaterally; positive Gaenslen's, Faber and compression tests bilaterally; no tenderness at the sciatic notch bilaterally and limited extension. Neurologic examination showed mild antalgic gait with a short stance phase on the right using a cane; normal touch and pinwheel sensation with exception of hypersensitivity in R L5 dermatome in right ankle and foot; normal strength bilateral lower extremities muscle group. The patient was diagnosed with chronic pain syndrome, postlaminectomy syndrome, lumbar region, spinal stenosis of lumbar region and depressive disorder. The provider requested authorization for the medications and procedures listed below.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 600 mg #150: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49.

Decision rationale: According to MTUS guidelines, “Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which 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.” There was no documentation that the patient is suffering from neuropathic pain including diabetic neuropathic pain or post-herpetic neuralgia condition. Therefore, the prescription of GABAPENTIN 600 MG #150 is not medically necessary.

Vicodin 5-500 #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 179.

Decision rationale: According to MTUS guidelines, ongoing use of opioids should follow specific rules: “(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 non adherent) 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." Vicodin is a short acting opioid recommeded for a short period of time in case of a breathrough pain or in combination with long acting medications in case of chronic pain. There is no clear evidence of a breakthough of back pain or acute lumbar root compresssion. In addition the efficacy for long term use of opoid is questionable and may affect the respitatory condition of this patient. Therefore, the request for Vicodin ES 750mg is not medically necessary.

Cymbalta 60 mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cymbalta Page(s): 43.

Decision rationale: According to MTUS guidelines, there is no high quality evidence to support the use of Cymbalta for lumbar radiculopathy and radicular pain There is no documentation about the efficacy of the drug for the management of the patient pain. Cymbalta is usually used for neuropathic pain and there is noclear evidence of neuropathic pain in this case. Therefore Cymbalta is not medically necessary.

Kadian 30 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain, Criteria for the use of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

Decision rationale: Kadian is a brand of morphine sulfate. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules:(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 non adherent) 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>Despite the continuous use of Kadian, there is no documentation of functional improvement and reduction in pain. There is no objective documentation of pain severity level to justify the use of Kadian in this patient. There is no recent evidence of objective monitoring of compliance of the patient with her medications. Therefore, the prescription of KADIAN 30MG #60 is not medically necessary

Amitriptyline 25 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressant for chronic pain Page(s): 13.

Decision rationale: According to MTUS guidelines, tricyclics (Amitriptyline is a tricyclic antidepressant) are generally considered as a first a first line agent for pain management unless they are ineffective, poorly tolerated or contraindicated.According to the patient file, there was no documentation of a specific objective neuropathic pain condition occurring on physical examination. There is no documentation of diabetic neuropathy or post-herpetic neuralgia. Based on the above, the prescription for Amitriptyline 25mg # 60 is not medically necessary.