MAXIMUS Federal Services

Case Number:	CM14-0081598		
Date Assigned:	07/18/2014	Date of Injury:	07/10/1995
Decision Date:	08/26/2014	UR Denial Date:	05/02/2014
Priority:	Standard	Application Received:	06/03/2014

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 Practice 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:

The patient is a 54-year-old with a reported date of injury of 07/10/1995. The patient has the diagnoses of lumbosacral disc degeneration (722.52), lumbago (724.2) and neuralgia/neuritis/radiculitis (729.2). The progress notes for the primary treating physician dated 04/09/2014 indicate the patient has complaints of pain in the lower back with radiation into both legs that is rated a 8/10. Physical exam shows lumbar paravertebral tenderness to palpation with spasm with decreased sensation along the left L4 and L% dermatome. The treatment plan consisted of continuation of his medications and a request for chiropractic care

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 300mg x30 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDS) Page(s): 16-19.

Decision rationale: The California chronic pain medical treatment guidelines section on AEDS states that recommended for neuropathic pain Gabapentin (Neurontin, Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and post

herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. One recommendation for an adequate trial with gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. (Dworkin, 2003) The patient should be asked at each visit as to whether there has been a change in pain or function. Current consensus based treatment algorithms for diabetic neuropathy suggest that if inadequate control of pain is found, a switch to another first-line drug is recommended. This patient continues to complain of pain despite an adequate trial of this medication. Per the guidelines, a switch to another first-line drug is recommended. Such as, Gabapentin 300mg is not medically necessary.

Percocet 10/325 x30 days: Overturned

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): 75-86.

Decision rationale: The California chronic pain medical treatment guidelines section on ongoing use of opioids states: 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 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 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 dairy 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. There is also no evidence that opioids showed long-term benefit or improvement in function when used as treatment for chronic back pain.

(Martell-Annals, 2007) Current studies suggest that the upper limit of normal for opioids prior to evaluation with a pain specialist for the need for possible continuation of treatment, escalation of dose, or possible weaning, is in a range from 120-180 mg morphine equivalents a day. (Ballantyne, 2006) (AMDG, 2007). The patient is currently taking 90 morphine equivalents per day and is in compliance with the above-mentioned criteria for ongoing use of opioids. Therefore, Percocet 10/325 is medically necessary.

Vimovo 500-20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-69.

Decision rationale: The requested medication is a combination of an NSAID and a proton pump inhibitor. The California chronic pain medical treatment guidelines recommend such a combination for patients at intermediate risk for gastrointestinal events and no cardiovascular disease. Risk is defined as: (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). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. There is nothing in the progress notes that places this patient as intermediate risk. Such as, Vimovo 500-20mg #60 is not medically necessary.