MAXIMUS Federal Services

Case Number:	CM14-0190782		
Date Assigned:	11/24/2014	Date of Injury:	02/11/1994
Decision Date:	01/28/2015	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	11/14/2014

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 and 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 52 year old female with an injury date on 02/11/1994. Based on the 10/07/2014 progress report provided by the treating physician, the diagnoses are: 1. Chronic pain syndrome2. Migraine UNSP without NTRC MGRN3. Pain in joint of multiple sites4. Carpal tunnel syndrome5. Encounter for long-term use of other medicationAccording to this report, the patient complains of "bilateral upper extremity pain." Pain is exacerbated by periods of increased activities and lifting of objects and "partially relieved by the use of analgesic medications and various types of injection therapy." Physical exam reveals "tenderness in the region concordant with the patient's described area of pain. Deep palpation result in distal radiation of the pain." Range of motion of the upper and lower extremities is limited. Soft tissue dysfunction and spasm are noted in the temporalis, cervical paraspinal and upper extremity region. Sensation of the region reveals allodynia and hypersensitivity throughout the affected area. The examination is unchanged from 08/12/2014 and 06/13/2014 exam. "The patient has been advised that they may remain off work due to their reported limitations imposed by the pain and suffering." There were no other significant findings noted on this report. The utilization review denied the request for (1)Amitriptyline HD 50mg #60 with 1 refill, (2) Meloxicam 7.5 with 1 refill, (3) Norco 10/325mg #90 with 3 refills, (4)Topiramate 100mg #60 with 1 refill, and (5)Propranolol 40mg #60 on 10/16/2014 based on the MTUS,ODG, and National Guidelines Clearinghouse. The requesting physician provided treatment reports from 01/23/2013 to 10/07/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Amitriptyline HCL 50mg #60 with 1 refill: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-15.

Decision rationale: According to the 10/07/2014 report, this patient presents with "bilateral upper extremity pain." Per this report, the current request is for 1 prescription of Amitriptyline HD 50mg #60 with 1 refill. This medication was first mentioned in the 03/29/2013 report; it is unknown exactly when the patient initially started taking this medication. The MTUS page 13 states, "Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur."In reviewing of the report, the treating physician mentioned that the patient pain is "partially relieved by the use of analgesic medications" and are "better, able to perform activities of daily living while they are receiving the current treatment." In this case, given that the patient's neuropathic pain and the treating physician documented the efficacy of the medication as required by the MTUS guidelines. Therefore, the request is medically necessary.

1 prescription of Meloxicam 7.5 with 1 refill: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Metaxalone (Skelaxin).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's Page(s): 22.

Decision rationale: According to the 10/07/2014 report, this patient presents with "bilateral upper extremity pain." Per this report, the current request is for 1 prescription of Meloxicam 7.5 with 1 refill. The Utilization Review denial letter certified the request with modification of no refill. The MTUS Guidelines page22 reveal the following regarding NSAID's, "Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted." Review of medical records did not indicate the patient's had been previously taking this medication. In this case, the request to start Meloxicam is supported by the guidelines. Therefore, the request is medically necessary.

1 prescription of Norco 10/325mg #90 with 3 refills: Upheld

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

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

Decision rationale: According to the 10/07/2014 report, this patient presents with "bilateral upper extremity pain." Per this report, the current request is for 1 prescription of Norco 10/325mg #90 with 3 refills. This medication was first mentioned in the 01/21/2013 report; it is unknown exactly when the patient initially started taking this medication. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "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 4A's (analgesia, ADLs, adverse side effects, and aberrant 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 records, the treating physician documented that the patient has "partially relieved by the use of analgesic medications and various types of injection therapy. "Patient confirm[s] that they are better, able to perform activities of daily living while they are receiving the current treatment." The patient has "not experience serious undue adverse side effect" and "have not displayed aberrant drug behaviors or signs of diversion since last visit."In this case, reports do not show documentation of pain assessment; no numerical scale is used describing the patient's function. A general statement regarding ADL's was mentioned but there is no demonstration of "significant" improvement in ADL's. The treating physician does not mention in what specific way the ADL's or function is improved. Aberrant drug seeking behavior and adverse side effect were mentioned. No return to work or opiate monitoring is discussed such as urine toxicology and CURES. Outcome measures are not documented as required by MTUS. No valid instruments are used to measure the patient's function which is recommended once at least every 6 months per MTUS. The treating physician has failed to properly document analgesia and ADL's as required by MTUS. Therefore the request is not medically necessary.

1 prescription of Topiramate 100mg #60 with 1 refill: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topiramate (Topamax); Antiepilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines antiepileptic drugsTopamax Page(s): 16-17, 21.

Decision rationale: According to the 10/07/2014 report, this patient presents with "bilateral upper extremity pain." Per this report, the current request is for 1 prescription of Topiramate 100mg #60 with 1 refill. This medication was first mentioned in the 01/21/2013 report; it is unknown exactly when the patient initially started taking this medication. Regarding Topiramate (Topamax), MTUS Guidelines page 21 states "Topiramate has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants have failed." MTUS Guidelines page 16 and 17 regarding antiepileptic drugs for chronic pain also states "that 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 for the

use of this class of medication for neuropathic pain had been directed at postherpetic neuralgia and painful polyneuropathy." Review of reports indicates that the patient has neuropathic pain. MTUS Guidelines support antiepileptic medications for the use of neuropathic pain. In this case, the treating physician mentioned that the patient pain is "partially relieved by the use of analgesic medications" and are "better, able to perform activities of daily living while they are receiving the current treatment." Given, that the patient's neuropathic pain and the treating physician documented the efficacy of the medication as required by the MTUS guidelines. Therefore, the request is medically necessary.

1 prescription of Sumavel Dosepro 6mg/0.5ml #5 with 1 refill: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines -Treatment in Worker's Compensation (ODG-TWC), Head Chapter, Triptans

Decision rationale: This patient presents with chronic pain syndrome and has a history of migraines. The current request is for Sumavel Dosepro 6mg/0.5ml with 1 refill. The Utilization review stated that the guidelines support the use of Triptans for migraine sufferers, however, the patient was scheduled to follow up in four weeks and modified the certification for Sumavel Dosepro 6mg/0.5mg with no refill. ODG-TWC guidelines, Head chapter has the following regarding Triptans for headaches: "Recommended for migraine sufferers. At marketed doses, all oral Triptans (e.g., Sumatriptan, brand name Imitrex) are effective and well tolerated. Differences among them are in general relatively small, but clinically relevant for individual patients." As medical records document, this patient has a history of severe migraines and the treating physician has made an initial request for the medication Sumavel. The requested Sumavel is medically necessary.