MAXIMUS Federal Services

Case Number:	CM14-0193518		
Date Assigned:	12/01/2014	Date of Injury:	07/07/2009
Decision Date:	01/13/2015	UR Denial Date:	10/23/2014
Priority:	Standard	Application Received:	11/18/2014

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 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:

This 69 year old male was injured 7/7/09. The mechanism of injury is not documented in the available records. This injured worker has had claims from 2003 and 2006 that resulted in bilateral shoulder, neck, back and left lower extremity pain. His work status for these prior injuries was permanent and stationary to allow standing and sitting as needed, lifting restriction of 15-20 pounds and preclude from squatting, stooping and bending repetitively. On 3/24/10 the injured worker underwent a cervical epidural steroid injection that decreased pain from 7/10 to settling at 5/10. In 2011 the injured worker had bilateral hip replacements. In 12/12 another epidural steroid injection was administered to the lumbar area with 90% improvement in low back pain for 6 months. On 11/12/13 he received a lumbar epidural steroid injection with no relief noted. He uses a walker for balance. On 5/16/13 the injured worker exhibited tenderness on palpation at the right and left upper trapezius and right paraspinous muscles with associated muscle tension and spasms. His range of motion of the cervical spine is decreased by 20% with flexion, 50% with extension, 15% with lateral tilt to the left and 20% with rotation to the left. He has had prior massage therapy with improved range of motion. The radiographs to date include MRI of the cervical spine (6/15/09 and 3/13/12) revealing cervical spondylosis with 3-4 mm combined disc bulges at C3-4,C4-5 and C5-6;T1-2 and T2-3: 3-4 mm right lateral combined subligamentous disc protrusion and spinal stenosis at T2-3; C6-5: 1-2 mm combined disc bulge and osteophyte ridge. MRI of the lumbar spine (8/2/09) reveals possible acute or subacute endplate fracture; degenerative changes at multiple levels and L5-S1 right posterolateral disc extrusion impinging upon the nerve root. Bilateral hip radiograph (2/10/10) revealed osteoarthritic changes. His diagnoses include pain in joint pelvis thigh s/p bilateral hip replacement 2/24/11 and lumbar disc displacement without myelopathy. Currently taking 21 medications and include gabapentin, Protonix, buprenorphine, Diclofenac, Norflex and

prescription for Anaprox. As of 12/1/14 the injured worker continues to experience bilateral hip and back pain. On 10/23/14 Utilization Review non-certified the request for buprenorphine 0.1 mg sublingual # 30 based on MTUS Chronic Pain Guidelines indicating the use of this medication for opiate detoxification. There is no documentation of previous opiate detoxification and no evidence of neuropathic type pain. MTUS Chronic Pain Guidelines do not consider this medication as first line agent for management of osteoarthritis. Gabapentin 600 mg #60 was non-certified based on MTUS guidelines supporting its use for management of neuropathic pain. Based on documentation, there is no evidence of radiculopathy on examination. Non-certification of Diclofenac sodium 1.5% 60 gm based on the use of this medication is not indicated for treatment of disorders of the hips, spine or shoulders, per MTUS Chronic Pain Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Buprenorphine 0.1mg Sublingual #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine (Butrans).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 26-27.

Decision rationale: This 69 year old male was injured 7/7/09. The mechanism of injury is not documented in the available records. This injured worker has had claims from 2003 and 2006 that resulted in bilateral shoulder, neck, back and left lower extremity pain. His work status for these prior injuries was permanent and stationary to allow standing and sitting as needed, lifting restriction of 15-20 pounds and preclude from squatting, stooping and bending repetitively. Diagnoses include pain in joint pelvis thigh s/p bilateral hip replacement 2/24/11 and lumbar disc displacement without myelopathy. Currently taking 21 medications and include gabapentin, Protonix, buprenorphine, Diclofenac, Norflex and prescription for Anaprox. Treatment included continuing with medication. Per MTUS Chronic Pain, Buprenorphine HCL/ Naloxone HCL is a scheduled III controlled substance recommended for treatment of opiate addiction or opiate agonist dependence. Review of available reports has no indication rationale or documented opioid addiction/dependency. Suboxone has one of the most high profile side effects of a scheduled III medication such as CNS & Respiratory depression, dependency, hepatitis/hepatic event with recommended abstinence from illicit use of ETOH and benzodiazepine of which the patient is prescribed Alprazolam. There is no mention the patient was intolerable to other medication like Neurontin or other opioids use. The risk of serious side effects (such as slow/shallow breathing, severe drowsiness/dizziness) may be increased if this medication is used with other products that may also affect breathing or cause drowsiness along with prescribed psychiatric medicines. Per the Guidelines, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial and use should be reserved for those with improved attributable functional outcomes. This is not apparent here as this patient reports no change in pain relief, no functional improvement in daily activities, and has not has not decreased in medical utilization or self-independence continuing to treat for chronic pain symptoms. There is also no notation of

any functional improvement while on the medication nor is there any recent urine drug screening results in accordance to pain contract needed in this case. Without sufficient monitoring of narcotic safety, efficacy, and compliance for this individual along with no weaning process attempted for this injury of 2009. The Buprenorphine 0.1mg Sublingual #30 is not medically necessary and appropriate.

Gabapentin tab 600mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs/Gabapentin Page(s): 18-19.

Decision rationale: This 69 year old male was injured 7/7/09. The mechanism of injury is not documented in the available records. This injured worker has had claims from 2003 and 2006 that resulted in bilateral shoulder, neck, back and left lower extremity pain. His work status for these prior injuries was permanent and stationary to allow standing and sitting as needed, lifting restriction of 15-20 pounds and preclude from squatting, stooping and bending repetitively. Diagnoses include pain in joint pelvis thigh s/p bilateral hip replacement 2/24/11 and lumbar disc displacement without myelopathy. Currently taking 21 medications and include gabapentin, Protonix, buprenorphine, Diclofenac, Norflex and prescription for Anaprox. Treatment included continuing with medication. Although Neurontin (Gabapentin) 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; however, submitted reports have not adequately demonstrated the specific symptom relief or functional benefit from treatment already rendered for this chronic 2009 injury. Medical reports have not demonstrated specific neurological deficits or neuropathic pain and medical necessity have not been established. The Gabapentin tab 600mg #60 is not medically necessary and appropriate.

Diclofenac Sodium 1.5% 60gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Anti-inflammatories.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: This 69 year old male was injured 7/7/09. The mechanism of injury is not documented in the available records. This injured worker has had claims from 2003 and 2006 that resulted in bilateral shoulder, neck, back and left lower extremity pain. His work status for these prior injuries was permanent and stationary to allow standing and sitting as needed, lifting restriction of 15-20 pounds and preclude from squatting, stooping and bending repetitively. Diagnoses include pain in joint pelvis thigh s/p bilateral hip replacement 2/24/11 and lumbar disc displacement without myelopathy. Currently taking 21 medications and include gabapentin, Protonix, buprenorphine, Diclofenac, Norflex and prescription for Anaprox. Treatment included

continuing with medication. Per MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical compound analgesic over oral NSAIDs or other pain relievers for a patient with multiple joint pain without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic to include a compounded NSAID over oral formulation for this chronic 2009 injury without documented functional improvement from treatment already rendered. It is also unclear why the patient is being prescribed 2 concurrent anti-inflammatories, oral Anaprox and topical Diclofenac posing an increase risk profile without demonstrated extenuating circumstances and indication. Guidelines do not recommend long-term use of NSAID without improved functional outcomes attributable to their use. The Diclofenac Sodium 1.5% 60gm is not medically necessary and appropriate.