MAXIMUS Federal Services

Case Number:	CM14-0197633		
Date Assigned:	12/05/2014	Date of Injury:	06/30/2008
Decision Date:	01/16/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	11/25/2014

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 Internal Medicine and is licensed to practice in New York. 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 55 year old female with a date of injury of 06/30/2008. The wind blew a cart into her back and then she was struck by a second cart. On 11/07/2008 she had gastric bypass surgery for morbid obesity. She had a L3-L4 and L4-L5 fusion, instrumentation and laminectomy on 08/01/2012. On 11/01/2013 Electromyogram (EMG) and Nerve Conduction Velocity (NCV) Studies revealed a chronic bilateral S1 radiculopathy. On 01/13/2014 she had a right radiofrequency ablation of right SI joint and nerve roots. On 05/05/2014 she had the same procedure on the left side. She had SI joint injections and epidural steroid injections. On 08/05/2014 her medications included Norco, MSContin, Lyrica, Soma, Prilosec and Naprosyn. On 09/09/2014 her back pain was 5/10. On 08/12/2014 and 09/09/2014, her medications included Norco, Zanaflex, Anaprox, Protonix, Cymbalta and Lyrica. On 10/23/2014 her medications included Gabpentin, MS Contin, Norco and Soma. On 10/28/2014 she had 6/10 low back pain primarily over the SI joint radiating to her buttock and legs. She was taking Cymbalta. Gait was normal. She could toe walk and heel walk. She had a normal lumbar lordosis. She had decreased sensation over the right S1 dermatome. Lumbar range of motion was decreased. Except for 4/5 bilateral hip flexion, lower extremity motor exam was normal. She had bilateral positive straight leg raising. SI joint provocative testing was positive bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 100mg #60 with 3 refill: 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: The previous request for Gabapentin was denied and she was to be weaned off this medication. California MTUS Chronic Pain notes that Gabapentin is an anti-convulsant that is effective against diabetic neuropathy and post-herpetic neuropathy - neither of which was present in this patient. There is no documentation that Gabapentin is effective treatment in this patient. Her gait is normal. Motor strength was normal. Continued Gabapentin is not consistent with MTUS guidelines.

MS Contin 30mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78 - 79..

Decision rationale: Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) Page 78 references the following: 4) On-Going Management. Actions Should Include:(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from asingle 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 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 drugescalation, 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. The documentation does not substantiate that the above criteria were met for continued opiate treatment.

Norco 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78 - 79.

Decision rationale: 4) On-Going Management. Actions Should Include:(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from asingle 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 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. The documentation does not substantiate that the above criteria for on-going opiate treatment were met.

Soma 350mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Soma Page(s): 29.

Decision rationale: Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) Page 29. Carisoprodol (Soma) Not recommended. This medication is not indicated for long-term use. Carisoprodol is acommonly prescribed; centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Carisoprodol is now scheduled in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. In regular abusers the main concern is the accumulation of meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. This includes the following: (1) increasing sedation of benzodiazepines or alcohol; (2) use to prevent side effects of cocaine;(3) use with tramadol to produce relaxation and euphoria; (4) as a combination withhydrocodone, an effect that some abusers claim is similar to heroin (referred to as a "Las Vegas Cocktail"); & (5) as a combination with codeine (referred to as "Soma Coma"). (Reeves, 1999) (Reeves, 2001) (Reeves, 2008) (Schears, 2004) There was a 300% increase in numbers of emergency room episodes related to carisoprodol from 1994 to 2005. (DHSS, 2005) Intoxication appears to include subdued consciousness, decreased cognitive function, and abnormalities of the eyes, vestibular function, appearance, gait and motor function. Intoxication includes the effects of both carisoprodol and meprobamate, both of which act on different neurotransmitters.(Bramness, 2007) (Bramness, 2004) A withdrawal syndrome has been documented that consists of insomnia, vomiting, tremors, muscle twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. This is similar to withdrawal from meprobamate. (Reeves, 2007) (Reeves, 2004) There is little research in terms of weaning of high dose carisoprodol and there is no standard treatment regimen for patients with known dependence. Most treatment includes treatment for symptomatic complaints of withdrawal. Another option is to switch to phenobarbital to prevent withdrawal with subsequent tapering. A maximum dose of phenobarbital is 500 mg/day and the taper is 30 mg/day with a slower taper in an outpatient setting. Tapering should be individualized for each patient. (Boothby, 2003).