

Case Number:	CM15-0001453		
Date Assigned:	01/12/2015	Date of Injury:	03/17/2002
Decision Date:	04/09/2015	UR Denial Date:	12/24/2014
Priority:	Standard	Application Received:	01/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Emergency Medicine

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 injured worker is a year-old female who was originally injured on 03/17/2002 due to cumulative trauma. She underwent surgery in 2002 for a lumbar fusion. She continues to have lower back pain that radiates into both legs. The diagnosis is lumbar radiculopathy and post laminectomy syndrome. The injured worker is currently using Endocet, Elavil, MS Contin, Gabapentin, which she states allow her to perform household chores, noting a 30% improvement in function with medications. From clinic visit on 01/15/2014, the primary treating physician noted antalgic gait, limited range of motion of the lumbar spine, tenderness in the right and left lumbar paravertebral regions at the L4-L5 and L5-S1 levels, extension of lumbar spine positive for pain, right and left lateral rotation of the lumbar spine positive for pain. The primary treating physician requested refill of all current medications, which was denied by utilization review. This request was then submitted for independent medical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription of Endocet 10/325mg #112: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain; Opioids, long-term assessment; Opioid hyperalgesia Page(s): 80-82; 88-89; 95-96.

Decision rationale: Endocet is a combination medication of oxycodone, an opioid, and acetaminophen. The use of opioids for chronic back pain appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. There is no evidence to recommend one opioid over another. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56% (a statistic limited by poor study design). Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. While the treating physician does not suspect drug abuse, the injured worker has been on opioids for quite some time with little improvement in function and little effort to wean from the current dosage. It is now suggested that rather than simply focus on pain severity, improvements in a wide range of outcomes should be evaluated, including measures of functioning, appropriate medication use, and side effects. Measures of pain assessment that allow for evaluation of the efficacy of opioids and whether their use should be maintained include the following: 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. A recent epidemiologic study found that opioid treatment for chronic non-malignant pain did not seem to fulfill any of key outcome goals including pain relief, improved quality of life, and/or improved functional capacity. The treating physician does state routine monitoring for improvement in function and monitoring of 4 A's (ADL's, analgesia, aberrant drug behavior, adverse events). In this case, the treating physician does document pain and functional improvement compared to baseline. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life, which is noted in the physician record. However, it appears to be the same notation in each separate visit, suggesting there has been little improvement with ongoing use of opioids. Therefore, given the significant duration of use of opioids with little change in dosage, frequency, or functional improvement, it does not appear to be within the MTUS guidelines to continue to utilize opioids for the treatment of chronic back pain for the injured worker. The request for Endocet 10/325 #112 is therefore not medically necessary.

One prescription of Elavil 25mg #28: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16.

Decision rationale: Elavil is the trade name for amitriptyline, a tricyclic antidepressant medication that is also used for treatment of chronic pain. It is recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally

considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects, including excessive sedation (especially that which would affect work performance), should be assessed. It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. The optimal duration of treatment is not known because most double-blind trials have been of short duration (6-12 weeks). It has been suggested that if pain is in remission for 3-6 months, a gradual tapering of anti-depressants may be undertaken. The injured worker continues to have low back pain, but the treating physician reports a 30% functional improvement with current use of medications. The treating physician also notes that depression is exacerbated by flare-ups in her chronic pain. There is no documentation of significant side effects. It is not appropriate to stop the medication based upon measurements of pain alone, and given that the injured worker does report a functional improvement with use of Elavil, it does appear to be supported by the MTUS guidelines for further use. Therefore, Elavil 25mg #28 is medically necessary. However, the primary treating physician should continue to reassess and should consider tapering the medication when appropriate.

One percutaneous spinal cord stimulator (SCS) trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulation (SCS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators; Psychological evaluations, IDDS & SCS (intrathecal drug delivery systems & spinal cord stimulators) Page(s): 105-107; 101.

Decision rationale: A spinal cord stimulator is recommended only for select cases when less invasive procedures have failed or are contraindicated, for specific conditions. One of those conditions is failed back syndrome (persistent pain in patients who have undergone at least one previous back operation). It is more helpful for lower extremity than low back pain, although both may benefit, with 40-60% success rate 5 years after surgery. It works best for neuropathic pain. Neurostimulation is generally considered ineffective in treating nociceptive pain. Furthermore, psychological evaluation is recommended before spinal cord stimulator (SCS) trial. The treating physician believes the injured worker has failed back syndrome. The pain of the injured worker localizes predominantly to the lower back, and without clear neuropathic symptoms such as burning, tingling, or numbness of the lower extremities, it is unclear if the injured worker would maximally benefit from implantation of a spinal cord stimulator. While the injured worker may have failed back syndrome, more importantly prior to this invasive procedure, there is no clear documentation of a psychological evaluation within the available records to ensure appropriateness and likelihood of success. Therefore, the request for percutaneous spinal cord stimulator does not meet the criteria laid forth in the MTUS guidelines, and is therefore not medically necessary.