

Case Number:	CM15-0006255		
Date Assigned:	01/26/2015	Date of Injury:	04/09/2010
Decision Date:	03/20/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	01/12/2015

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: Physical Medicine & Rehabilitation

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 56 year old male sustained an industrial injury on 4/9/10, with subsequent ongoing low back pain. No recent magnetic resonance imaging lumbar spine was found within the medical record submitted for review. In a PR-2 dated 12/5/14, the injured worker complained of lumbar spine pain with radiation down the right leg. The injured worker reported that medications helped improve the pain by 50 per cent. Physical exam was remarkable for limited range of motion to the lumbar spine with 45 degree flexion and pain upon extension. Current diagnoses included lumbar disc degenerative disease and radiculitis. The treatment plan included refilling medications, continuing home exercise program and a TENS unit. On 12/17/14, Utilization Review modified a request for Percocet 10/325 mg #150 to Percocet 10/325 mg #75 and Gralise 600 mg #90 to Gralise 600 mg #45. Utilization Review noncertified a request for Ibuprofen 800 mg #60. Utilization Review cited CA MTUS Chronic Pain Medical Treatment Guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 800 mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

Decision rationale: This patient presents with persistent low back pain and pain to the right side of the lower back which radiates to the right lower extremity down to the leg. The current is for ibuprofen 800 mg #60. Regarding NSAIDs, the MTUS Chronic Pain Medical Treatment Guidelines page 22 states; antiinflammatories 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. A comprehensive review of clinical trials of the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective nonsteroidal antiinflammatory drugs-NSAIDs-in chronic LBP and of antidepressants in chronic LBP. The utilization review denied the request stating that "the medical records indicate that the medication is tolerated well and decreased the pain by 50%. However, the medical records lack documentation of the time frame of efficacy, the efficacy of functional status that the medication provides, and the pain rating pre and post medication." Review of the medical file indicates the patient has been utilizing ibuprofen since 08/12/2014. Progress report dated 12/05/2014 indicates that medications are well tolerated and patient's current pain level is 8/10 and with medication, pain is decreased by 50%. In this case, given the patient's continued complaints of pain and treating physician's documentation that medications currently relieved pain by average 50%, the requested ibuprofen IS medically necessary.

Percocet 10/325 mg #150: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: This patient presents with continued low back pain that radiates into the right lower extremity. The current request is for Percocet 10/325 mg #150. For chronic opiates, the MTUS Guidelines page 88 and 89 states, "pain should be assessed at each visit, and function should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As including analgesia, ADLs, adverse side effects, and adverse behavior. "Pain assessment" or outcome measures also should be provided which 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 the medical file indicates the patient has been utilizing Percocet since at least 08/12/2014. Progress reports indicate the patient has approximately 50% decrease in symptoms with current medication intake. The patient states that medications allow her to perform basic activities of daily living such as getting out of bed and allows her to sleep at night. In this case, recommendation for further use of Percocet cannot be made as the treating physician has not been provided any discussions regarding possible aberrant behavior as required by MTUS for opiate management. There are no

urine drug screens, CURES report, pain contracts, or any discussion regarding opiate management issues. The MTUS Guidelines requires documentation of all 4As for continued opiate use. The treating physician has failed to provide the minimum requirements of documentation that are outlined in MTUS for continued opiate use. The requested Percocet IS NOT medically necessary and recommendation is for slow weaning per MTUS.

Gralise 600 mg #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs Page(s): 18-19.

Decision rationale: This patient presents with chronic low back pain that radiates into the right lower extremity. The current request is for Gralise 600 mg #90. The MTUS Guidelines page 18 and 19 has the following regarding gabapentin, "gabapentin has shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered the first-line treatment for neuropathic pain." Review of the medical file indicates the patient has been utilizing Gralise since at least 08/12/2014. Progress reports note that the patient receives excellent pain relief with the use of this medication. It was noted that the patient is unable to sleep throughout the night without taking Gralise. The treating physician states that "she had improved function throughout the day with Gralise when compared to the generic Neurontin and gabapentin." The utilization review denied the request stating that "the medical records lack documentation of the time frame of the efficacy, the efficacy of functional status that the medication provides, and the pain rating pre and post medication." In this case, the patient presents with radicular symptoms and the treating physician has documented that Gralise provides 40-50% pain relief." Given this medication's efficacy, the requested Gralise IS medically necessary.