

Case Number:	CM15-0147446		
Date Assigned:	08/10/2015	Date of Injury:	07/01/2002
Decision Date:	09/23/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/29/2015

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:

The injured worker is a 64 year old male, who sustained an industrial injury on 7-1-02. Initial complaints were not reviewed. The injured worker was diagnosed as having right shoulder sprain-strain; right shoulder impingement syndrome; adhesive capsulitis right shoulder; right wrist sprain-strain; lumbar spine sprain-strain; lumbar multilevel degenerative disc disease; chronic right lumbar radiculopathy; neuropathic pain right leg; gait disorder associated with right leg pain-weakness; right knee strain-sprain; right knee patellofemoral pain; chronic pain syndrome. Treatment to date has included status post shoulder arthroscopy; status post multiple lumbar surgeries with anterior interbody fusion L4-S1 (8-5-03); status post revision lumbar surgery with complications by infection; status post failed spinal cord stimulator trial (2009); physical therapy; medications. Currently, the PR-2 notes dated 6-18-15 indicated the injured worker complains of right knee, right shoulder, right wrist and low back pain. He complains of achy, throbbing and numbness with a severity of pain at 8 out of 10. He reports modifying factors are worse with everything and the pains are constant. He has numbness, headaches, joint pain and stiffness, depression, anxiety, stress and insomnia are reported. His surgical history includes right shoulder surgery 12-2003, low back surgery in 2003, and then 3 separate low back surgeries with complications due to infection in 4-2005, 5-2005 and 6-2005. He has had facet, epidural, cortisone and Toradol type injections. He has trialed a spinal cord stimulator but failed in 2009. The lumbar spine exam notes a decreased range of motion fur to pain and ambulates with an antalgic gait. The provider is requesting authorization of Neurontin 800mg #60; Neurontin 400mg #30; Anaprox DS sodium 550mg #60; Prilosec 20mg #30 and Lidoderm 5% topical #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 800mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18, 19.

Decision rationale: The patient presents with right knee, right shoulder, right wrist and low back pain rated 8/10. The request is for Neurontin 800MG #60. The request for authorization is dated 07/06/15. The patient is status post right shoulder surgery, 12/2003. Status post 4 back surgeries, 2003, 04/2005, 05/2005, and 06/2005. Physical examination of the lumbar spine reveals decreased painful range of motion. Patient's medications include Protonix, Neurontin, Anaprox and Lidoderm. Per progress report dated 06/18/15, the patient is permanent and stationary per AME. MTUS has the following regarding Gabapentin on pg 18, 19: "Gabapentin (Neurontin, Gabarone, generic available) 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." MTUS p60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Treater does not specifically discuss this medication. Treater does not document when Neurontin was initiated. The patient presents with severe chronic pain, a neuropathic condition for which Neurontin is indicated. However, the treater does not document efficacy in terms of reduction in pain and improvement in function, as required by MTUS page 60 for all chronic pain medications. Therefore, the request IS NOT medically necessary.

Neurontin 400mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18, 19.

Decision rationale: The patient presents with right knee, right shoulder, right wrist and low back pain rated 8/10. The request is for Neurontin 400MG #30. The request for authorization is dated 07/06/15. The patient is status post right shoulder surgery, 12/2003. Status post 4 back surgeries, 2003, 04/2005, 05/2005, and 06/2005. Physical examination of the lumbar spine reveals decreased painful range of motion. Patient's medications include Protonix, Neurontin, Anaprox and Lidoderm. Per progress report dated 06/18/15, the patient is permanent and stationary per AME. MTUS has the following regarding Gabapentin on pg 18, 19: "Gabapentin

(Neurontin, Gabarone, generic available) 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." MTUS p60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Treater does not specifically discuss this medication. Treater does not document when Neurontin was initiated. The patient presents with severe chronic pain, a neuropathic condition for which Neurontin is indicated. However, the treater does not document efficacy in terms of reduction in pain and improvement in function, as required by MTUS page 60 for all chronic pain medications. Therefore, the request IS NOT medically necessary.

Anaprox DS sodium 550mg #60: Upheld

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: The patient presents with right knee, right shoulder, right wrist and low back pain rated 8/10. The request is for Anaprox DS sodium 550MG #60. The request for authorization is dated 07/06/15. The patient is status post right shoulder surgery, 12/2003. Status post 4 back surgeries, 2003, 04/2005, 05/2005, and 06/2005. Physical examination of the lumbar spine reveals decreased painful range of motion. Patient's medications include Protonix, Neurontin, Anaprox and Lidoderm. Per progress report dated 06/18/15, the patient is permanent and stationary per AME.MTUS Chronic Pain Medical Treatment Guidelines, pg 22 for Anti-inflammatory medications states: 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. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective non-steroidal anti-inflammatory drugs (NSAIDs) in chronic LBP and of antidepressants in chronic LBP. Treater does not specifically discuss this medication. Treater does not document when Anaprox was initiated. MTUS supports the use of anti-inflammatories as traditional first line of treatment for pain. However, the treater does not specifically discuss efficacy of Anaprox for the patient. MTUS Guidelines page 60 states that when medications are used for chronic pain, recording of pain and function needs to be provided. Given the lack of documentation, the request does not meet guidelines indication. Therefore, the request IS NOT medically necessary.

Prilosec 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

Decision rationale: The patient presents with right knee, right shoulder, right wrist and low back pain rated 8/10. The request is for Prilosec 20MG #30. The request for authorization is dated 07/06/15. The patient is status post right shoulder surgery, 12/2003. Status post 4 back surgeries, 2003, 04/2005, 05/2005, and 06/2005. Physical examination of the lumbar spine reveals decreased painful range of motion. Patient's medications include Protonix, Neurontin, Anaprox and Lidoderm. Per progress report dated 06/18/15, the patient is permanent and stationary per AME. MTUS pg 69, NSAIDs, GI symptoms & cardiovascular risk Section states, "Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." Treater does not specifically discuss this medication. Treater does not document when Prilosec was initiated. In this case, treater has not documented GI assessment to warrant a prophylactic use of a PPI. In addition, treater has not indicated how the patient is doing, what gastric complaints there are, and why he needs to continue. Additionally, the patient is prescribed Anaprox, an NSAID; however, the request for Anaprox has not been authorized. Therefore, the request IS NOT medically necessary.

Lidoderm 5% topical #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111, 57.

Decision rationale: The patient presents with right knee, right shoulder, right wrist and low back pain rated 8/10. The request is for Lidoderm 5% topical #30. The request for authorization is dated 07/06/15. The patient is status post right shoulder surgery, 12/2003. Status post 4 back surgeries, 2003, 04/2005, 05/2005, and 06/2005. Physical examination of the lumbar spine reveals decreased painful range of motion. Patient's medications include Protonix, Neurontin, Anaprox and Lidoderm. Per progress report dated 06/18/15, the patient is permanent and stationary per AME. MTUS guidelines page 57 states, "topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica." Page 112 also states, "Lidocaine indication: neuropathic pain. Recommended for localized peripheral pain." ODG guidelines, Pain (Chronic) Chapter under Lidoderm (lidocaine patch) states: "Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. A Trial of patch treatment is recommended for a short-term period (no more than four weeks). This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day). Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued." Treater does not specifically discuss this medication. Treater does not document when Lidoderm was initiated. In this case, the patient continues with localized peripheral pain in the wrist. However, treater does not discuss or document pain reduction and functional improvement with use of Lidoderm Patches as required by ODG. Therefore, the request IS NOT medically necessary.