

Case Number:	CM15-0163619		
Date Assigned:	08/31/2015	Date of Injury:	01/27/2000
Decision Date:	10/07/2015	UR Denial Date:	07/23/2015
Priority:	Standard	Application Received:	08/20/2015

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 60 year old male with an industrial injury dated 01-27-2000. The injured worker's diagnoses include post lumbar laminectomy syndrome, lumbar radiculopathy, chronic back pain and spondylolisthesis. Treatment consisted of diagnostic studies, prescribed medications, physical therapy, home exercises and periodic follow up visits. In a progress note dated 07-14-2015, the injured worker reported low back pain with radiation down bilateral legs. The injured worker rated pain a 3 out of 10 with medications and 8 out of 10 without medication. Objective findings revealed restricted cervical range of motion, restricted thoracic range of motion, and thoracic paravertebral tenderness. Lumbar spine exam revealed loss of normal lordosis, restricted lumbar range of motion limited by pain, hypertonicity, spasm, tenderness, and tight muscle band in the bilateral paravertebral muscles. Positive straight leg raises and tenderness over the sacroiliac spine were also noted on exam. The treatment plan consisted of medication management and orthopedic bracing. The treating physician prescribed Gabapentin 300mg #180, Norco 10-325mg #90, Mobic 7.5mg #30 with 5 refills and Cymbalta 60mg #30 with 5 refills, now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 300mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Based on the 7/14/15 progress report provided by the treating physician, this patient presents with low back pain radiating down bilateral legs, and to postero-lateral thigh and calf including the lateral/bottom/dorsal aspect of the foot, with pain rated 3/10 with medications and 8/10 without medications. The treater has asked for Gabapentin 300mg #180 on 7/14/15. The patient's diagnoses per request for authorization dated 7/14/15 are post lumbar laminect syndrome, lumbar radiculopathy, chronic back pain, s/p L3-4 and L4-5 fusion, spondylolisthesis, and lumbar facet syndrome. The patient's activity level has increased, and is active for 6 hours a day per 7/14/15 report. The patient is s/p lumbar facet injections with no improvement, spinal cord stimulator which was not effective, and a posterior L3-5 fusion from 2007 per 5/23/15 report. The patient completed previous physical therapy of unspecified sessions and is doing a home exercise program including a mile of walking on regular basis per 5/23/15 report. The patient's work status is not included in the provided documentation. MTUS has the following regarding Gabapentin on pg 18, 19, Specific Anti-epilepsy Drugs section: "Gabapentin (Neurontin, Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and post-therapeutic neuralgia and has been considered as a first-line treatment for neuropathic pain." The treater does not discuss this request in the reports provided. In this case, the patient has been taking Gabapentin since at least 1/27/15 report. The treater does not document efficacy in terms of reduction in pain and improvement, as required by MTUS page 60 for all pain medications. Additionally, there is no specific diagnosis of neuropathic pain for which Gabapentin is indicated. Hence, the request IS NOT medically necessary.

Norco 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain, Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: Based on the 7/14/15 progress report provided by the treating physician, this patient presents with low back pain radiating down bilateral legs, and to postero-lateral thigh and calf including the lateral/bottom/dorsal aspect of the foot, with pain rated 3/10 with medications and 8/10 without medications. The treater has asked for Norco 10/325mg #90 on 7/14/15. The patient's diagnoses per request for authorization dated 7/14/15 are post lumbar laminect syndrome, lumbar radiculopathy, chronic back pain, s/p L3-4 and L4-5 fusion, spondylolisthesis, and lumbar facet syndrome. The patient's activity level has increased, and is active for 6 hours a day per 7/14/15 report. The patient is s/p lumbar facet injections with no improvement, spinal cord stimulator which was not effective, and a posterior L3-5 fusion from 2007 per 5/23/15

report. The patient completed previous physical therapy of unspecified sessions and is doing a home exercise program including a mile of walking on regular basis per 5/23/15 report. The patient's work status is not included in the provided documentation. MTUS, criteria for use of opioids section, pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS, criteria for use of opioids section, page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that 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. MTUS, criteria for use of opioids section, p 77, states that "function should include social, physical, psycho-logical, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS, medications for chronic pain section, page 60 states that "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity." MTUS p 90 states, "Hydrocodone has a recommended maximum dose of 60mg/24 hrs." The treater does not discuss this request in the reports provided. Patient has been taking Norco since 1/27/15 and in reports dated 3/24/15 and 7/14/15. MTUS requires appropriate discussion of all the 4A's. The treater does state that his medications which include Norco are "working well." The patient wants to decrease Norco per 2/24/15 report. The patient's prescription of Norco was decreased from QID to TID as of May 2015 per 7/14/15, and the patient has been doing well on new dosage. However, in addressing the 4A's, the treater does not discuss how this medication significantly improves patient's activities of daily living. No validated instrument is used to show analgesia. There is no recent UDS, although a CURES report from 4/21/15 was appropriate. Given the lack of documentation as required by MTUS, the request does not meet the specifications given by the guidelines. In addition, MTUS p 90 states that Hydrocodone has a recommended maximum dose of 60mg/24 hrs. Therefore, the request IS NOT medically necessary.

Mobic 7.5mg #30 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Anti-inflammatory medications.

Decision rationale: Based on the 7/14/15 progress report provided by the treating physician, this patient presents with low back pain radiating down bilateral legs, and to postero-lateral thigh and calf including the lateral/bottom/dorsal aspect of the foot, with pain rated 3/10 with medications and 8/10 without medications. The treater has asked for Mobic 7.5mg #30 with 5 refills on 7/14/15. The patient's diagnoses per request for authorization dated 7/14/15 are post lumbar laminect syndrome, lumbar radiculopathy, chronic back pain, s/p L3-4 and L4-5 fusion, spondylolisthesis, and lumbar facet syndrome. The patient's activity level has increased, and is active for 6 hours a day per 7/14/15 report. The patient is s/p lumbar facet injections with no improvement, spinal cord stimulator which was not effective, and a posterior L3-5 fusion from 2007 per 5/23/15 report. The patient completed previous physical therapy of unspecified

sessions and is doing a home exercise program including a mile of walking on regular basis per 5/23/15 report. The patient's work status is not included in the provided documentation. MTUS Guidelines, Anti-inflammatory medications section, page 22 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 nonsteroidal anti-inflammatory drugs (NSAIDs) in chronic LBP and of antidepressants in chronic LBP." MTUS, Medications for Chronic Pain, pg. 60: Recommended as indicated below. Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. The treater does not discuss this request in the reports provided. Patient has been taking Mobic since 1/27/15 and in reports dated 3/24/15 and 7/14/15. The treater does state that his current medication regimen which are "working well" but does not specifically mention Mobic. MTUS guidelines page 60 require recording of pain and function when medications are used for chronic pain. Due to a lack of documentation of effectiveness over 5 months of use, the requested Mobic IS NOT medically necessary.

Cymbalta 60mg #30 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain.

Decision rationale: Based on the 7/14/15 progress report provided by the treating physician, this patient presents with low back pain radiating down bilateral legs, and to postero-lateral thigh and calf including the lateral/bottom/dorsal aspect of the foot, with pain rated 3/10 with medications and 8/10 without medications. The treater has asked for Cymbalta 60mg #30 with 5 refills on 7/14/15 "for musculoskeletal low back pain and nerve pain." The patient's diagnoses per request for authorization dated 7/14/15 are post lumbar laminect syndrome, lumbar radiculopathy, chronic back pain, s/p L3-4 and L4-5 fusion, spondylolisthesis, and lumbar facet syndrome. The patient's activity level has increased, and is active for 6 hours a day per 7/14/15 report. The patient is s/p lumbar facet injections with no improvement, spinal cord stimulator which was not effective, and a posterior L3-5 fusion from 2007 per 5/23/15 report. The patient completed previous physical therapy of unspecified sessions and is doing a home exercise program including a mile of walking on regular basis per 5/23/15 report. The patient's work status is not included in the provided documentation. MTUS guidelines Anti-depressants for Chronic pain section, pg. 16-17: Duloxetine (Cymbalta) is FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. Used off-label for neuropathic pain and radiculopathy. Duloxetine is recommended as a first-line option for diabetic neuropathy. Trial period: Some relief may occur in first two weeks; full benefit may not occur until six weeks. The patient has been utilizing Cymbalta since at least 1/27/15. Although this patient meets guidelines indications for the use of Cymbalta, recommendation for further use cannot be supported as there is no discussions regarding efficacy. Given this patient has been using this medication chronically, with no documentation of specific efficacy and functional benefit, the request IS NOT medically necessary.

