

Case Number:	CM15-0186449		
Date Assigned:	09/28/2015	Date of Injury:	10/05/2011
Decision Date:	11/03/2015	UR Denial Date:	09/11/2015
Priority:	Standard	Application Received:	09/22/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 33 year old male, who sustained an industrial injury on 10-5-2011. The injured worker is undergoing treatment for: neck and low back pain, cervical degenerative disc disease, and lumbar facet osteoarthritis, myofascial pain, neck muscle strain, neck sprain. On 7-24-15, he reported neck and low back pain. He rated the pain 5 out of 10 without medications and 20 out of 10 with medications. He reported that "he is doing better with medication and he is going to go for acupuncture". On 8-28-15, he reported neck and low back pain. He rated his pain 4-5 out of 10 without medications and 2 out of 10 with medications. He indicated he is more active and currently only requires one Norco per day. He also reported Neurontin "helps him greatly with his neuropathic pain". He denied side effects to medications. Physical findings revealed his cervical spine to be stable, lumbar spine with positive left straight leg raise test and decreased range of motion; and dysesthesia is noted down the left leg to the calf. The record does not discuss the efficacy of Norco. The record does not discuss the duration of pain relief or how long it takes for pain relief to occur. There is no discussion of aberrant behaviors or side effects. The treatment and diagnostic testing to date has included: medications, TENs, lumbar facet injection (4-1-13), magnetic resonance imaging of the lumbar spine (12-28-12), counseling sessions, heat, ice, gentle stretching, acupuncture (amount completed is unclear), urine drug screen (4-24-15). Medications have included: Norco (since at least January 2013, possibly longer), Norflex, Gabapentin (Neurontin (since at least January 2013, possibly longer), Naprosyn, Vicodin, Prilosec. Current work status: Not currently working. The request for authorization is for: Norco 5-325mg quantity 30 and 3 refills, Neurontin 300mg quantity 60 and 3 refills. The UR dated 9-11-2015: non-certified the request for Norco 5-325mg quantity 30 and 3 refills, Neurontin 300mg quantity 60 and 3 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 5/325mg, #30 with 3 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain Chapter Opioids, criteria for use.

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

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single 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 non-adherent) 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 diary 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 non-opioid 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. When to Continue Opioids; (a) If the patient has returned to work. (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004). The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is documentation of significant subjective improvement in pain such as VAS scores with pain decreasing from a 4/10 to a 2/10. There is also objective measure of improvement in function. For these reasons the criteria set forth above of ongoing and continued used of opioids have been met. Therefore, the request is medically necessary.

Neurontin 300mg, #60 with 3 refills: Overturned

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: The California chronic pain medical treatment guidelines section on Neurontin states: 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. (Backonja, 2002) (ICSI, 2007) (Knotkova, 2007) (Eisenberg, 2007) (Attal, 2006) This RCT concluded that gabapentin monotherapy appears to be efficacious for the treatment of pain and sleep interference associated with diabetic peripheral neuropathy and exhibits positive effects on mood and quality of life. (Backonja, 1998) It has been given FDA approval for treatment of post-herpetic neuralgia. The number needed to treat (NNT) for overall neuropathic pain is 4. It has a more favorable side-effect profile than Carbamazepine, with a number needed to harm of 2.5. (Wiffen2-Cochrane, 2005) (Zaremba, 2006) Gabapentin in combination with morphine has been studied for treatment of diabetic neuropathy and postherpetic neuralgia. When used in combination the maximum tolerated dosage of both drugs was lower than when each was used as a single agent and better analgesia occurred at lower doses of each. (Gilron-NEJM, 2005) Recommendations involving combination therapy require further study. The requested medication is a first line agent to treatment neuropathic pain. The patient does have a diagnosis of neuropathic pain in the form of lumbar radiculopathy. Therefore, the request is medically indicated.