

Case Number:	CM15-0192267		
Date Assigned:	10/06/2015	Date of Injury:	11/20/2002
Decision Date:	11/16/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	09/30/2015

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 57 year old female, who sustained an industrial injury on 11-20-02. The injured worker was diagnosed as having carpal tunnel syndrome; RSD; chronic pain syndrome; depression. Treatment to date has included medications. Currently, the PR-2 notes dated 9-17-15 indicated the injured worker came in the office for a follow-up visit. She reports still having chronic right forearm-wrist pain and weak, poor tolerance to repetitive activities. She reports sleep impairment due to pain and tingling. The provider documents "She states she has a new pain in the dorsum side to the old surgical area of the radial side of right wrist, it swells. Not much improvement but stable under current management. She wears the splint on right wrist most of the time with periodical taking off. No more ganglion blocks due to lack of sustainable benefit." Objective findings are documented as "ambulates without assistive device, wearing the wrist splints. Diminished range of motion, palpatory tenderness to right forearm-wrist, without edema (partly due to compression of splint), and ecchymosis of the pain area she complains. Deep tendon reflexes 2+, Hoffmann's negative, hyperalgesic to touch compared with the left, handgrip right than the left. X-ray of the right wrist 11-21-14 reveals minor degeneration of 1st CMC, otherwise unremarkable. Review of systems: Review of pain scale: constant-always pain, currently 9 out of 10; fluctuates between 4 and 10 out of 10; functional status: Overall 3 out of 10; pain control 3 out of 10." The provider notes a treatment plan and documents "For her complicated long history of depression, chronic pain I need and repeat the request for outside consultation, treatment options and opinions about the chronic pain with the HELP program. The non-pharmacological approach: 1) continue to wear the B-L wrist splint for her wrist pain related to

tendonitis and CTS, to avoid escalating oral analgesics. 2) Encourage to keep environment warm and continue HEP. 3) Ice pack on wrist PRN #3. Pharmacologic approach: 1) to minimize exposure to SE of opioids, continue topical compound cream. Norco 7.5-325 mg #1 PO BID - TID PRN #40 to replace MS IR 15mg (ultra rapid 2D6 metabolizer) Gabapentin 400mg #1 tid #90; Zipsor 25mg 1 PO qd BID PRN #30 refill x3, for insomnia amitriptyline 25mg #1-2 PO qhs PRN #30 without future auto-refill; Amrix 15mg #1 QD prn #10 applicant insists brand name only. Follow-up 2 weeks to evaluate the titration and med change." There are multiple pharmacy reviews and other PR-2's. It appears by the medical documentation submitted, the injured worker has been on these medications long-term, but documentation is only the past year. There is no definitive start date for these medications. A Request for Authorization is dated 9-30-15. A Utilization Review letter is dated 9-24-15 for non-certification of Norco 7.5-325 mg #40; Gabapentin 400 mg #90 and Zipsor 25 mg #28. A request for authorization has been received for Norco 7.5-325 mg #40; Gabapentin 400 mg #90 and Zipsor 25 mg #28.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 7.5/325 mg #40: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): 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 dairy 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. The California MTUS states: 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 no documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function or activity specifically due to the medication. Therefore not all criteria for the ongoing use of opioids have been met and the request is not medically necessary.

Gabapentin 400 mg #90: Overturned

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

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 post herpetic 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 post herpetic 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 patient has the diagnosis of neuropathic pain in the form of carpal tunnel syndrome and RSD. Therefore, the request is medically necessary.

Zipsor 25 mg #28: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The California chronic pain medical treatment guidelines section on NSAID therapy states: Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) This medication is recommended for the shortest period of time and at the lowest dose possible. The dosing of this medication is within the California MTUS guideline recommendations. The definition of shortest period possible is not clearly defined in the California MTUS. Therefore, the request is medically necessary.