MAXIMUS Federal Services

Case Number:	CM15-0204534		
Date Assigned:	10/21/2015	Date of Injury:	06/28/2001
Decision Date:	12/09/2015	UR Denial Date:	09/29/2015
Priority:	Standard	Application Received:	10/19/2015

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: Colorado
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 58 year old, female who sustained a work related injury on 6-28-01. A review of the medical records shows she is being treated for low back pain. In the progress notes dated 7-29-15, the injured worker reports continued low back pain. Without medications, she rates her pain a 10 out of 10. With medications, her pain decreases and her function increases. With medications, she improves by 75%. On physical exam dated 7-29-15, the exam is difficult to decipher. Treatments have included H-wave therapy, physical therapy, medications, activity modifications and prolonged rest. Current medications include Percocet, Klonopin and Neurontin. She has been taking the Percocet, Klonopin and Neurontin since at least April, 2015. She is not working. The treatment plan includes a request for lumbar epidural steroid injections, refills of medications, a dose of Toradol intramuscular injection and a urine drug screen. The Request for Authorization dated 7-29-15 has requests for lumbar epidural steroid injections, for Percocet, Klonopin, Neurontin, a urine drug screen and a Toradol injection. In the Utilization Review dated 9-29-15, the requested treatments of Percocet 10-325mg. three times a day, #180, Neurontin 600mg. three times a day, #90 and Klonopin 1mg. at bedtime #30 are modified to Percocet 10-325mg. #90, Klonopin 1mg. #15 and Neurontin 600mg. #45. The April 1, 2015 clinic note requests lumbar epidural steroids, the treating physician indicating patient has failed conservative therapy with oral medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Klonopin 1mg at bedtime #30: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

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

Decision rationale: Benzodiazepines are not recommended for long term use. Per the guidelines, benzodiazepines can be used short term, no more than 4 weeks, in chronic pain, and in other indications including sedative/hypnotic, anxiolytic, anti-epileptic, and muscle relaxation. Chronic benzodiazepine use is rarely indicated, and can make symptoms worse over time. Tolerance to the anxiolytic and sedative properties of benzodiazepines develops within first few months of use. The records supplied for review are of very poor quality and much is illegible. Per the records supplied, the patient has been taking Klonopin for several months at current dose. Patient taking at bedtime per prescription, so unclear in the records if patient has been taking it strictly for sleep, or for multiple reasons, including chronic pain. It is unclear in the records exactly how the Klonopin helps the patient. Regardless, as it is not recommended for long term use for any condition the patient has documented, the request for Klonopin is not medically necessary.

Neurontin 600mg TID #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: Per the guidelines, Gabapentin, an anti-epileptic drug, is recommended for treatment of neuropathic pain, as is the class of anti-epilepsy drugs (AED's). These drugs have been most studied for treatment of post herpetic neuralgia and diabetic neuropathy. Because neuropathic pain is often multifactorial with variable symptoms and physical findings, there is a lack of agreement among experts on the best treatment. There is also a lack of quality evidence for any specific treatment for neuropathic pain with most randomized control trials addressing the above mentioned post-herpetic neuralgia and other polyneuropathies, and few randomized control trials for central pain, none for treatment of radicular pain. As there is a lack of good evidence / expert agreement, per the guidelines, the choice of a specific agent for treatment of neuropathic pain and the decision to continue treatment with a specific anti-epileptic drug are generally determined by efficacy of the medication and any adverse reactions experienced. When using anti-epileptic drugs for treatment of neuropathic pain, the guidelines define a "good" response to the use of AED's as a 50% reduction in pain and a "moderate" response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" for the following: (1) a switch to a

different first-line agent (2) combination therapy if treatment with a single drug agent fails. (Eisenberg, 2007) (Jensen, 2006) Per the guidelines, patient pain levels and functional improvement while taking medications should be documented at follow up appointments. Gabapentin specifically has good evidence to support its use, first-line, in neuropathic pain. (Backonja, 2002) (ICSI, 2007) (Knotkova, 2007) (Eisenberg, 2007) (Attal, 2006) It is FDA-approved for use in post-herpetic neuralgia. In addition to use in neuropathic pain, Gabapentin has evidence to support its use in spinal stenosis, fibromyalgia, spinal cord injury, and some evidence to support its use in post-operative pain to decrease anxiety and need for opioids. For the patient of concern the records available for review are of very poor quality and much is illegible. Per the records, there is documentation that patient has had a "good" response (75% reduction in pain) overall to her regimen which includes Gabapentin. The records include discussion of improved function as well. As patient has achieved recommended level of pain relief and has documented functional improvement with Gabapentin, the Gabapentin is medically indicated.

Percocet 10/325mg TID #180: 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, criteria for use, Opioids for chronic pain, Opioids, dealing with misuse & addiction, Opioids, long-term assessment.

Decision rationale: The Guidelines establish criteria for use of opioids, including long term use (6 months of more). When managing patients using long term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain / work / interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant / addictive behavior should be addressed if present. (Address diversion or procuring prescriptions from more than one provider.) Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. The exact frequency will be per provider discretion based on need. To summarize the above, the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. 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) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of Opioids. 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians

will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient. Per the Guidelines, Chelminski defines "serious substance misuse" as meeting ANY of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005) 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits "serious non-adherence" (including urine drug testing negative for prescribed substances on 2 occasions). 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work? Has patient had improved function and decreased pain with the opioids? The records supplied for review are of very poor quality and much is illegible. While the patient of concern reports improved pain on current regimen which includes Percocet, there is no documented objective assessment of functional improvement. There is discussion of functional improvement in general terms, but n o objective assessment of function. While mention of functional improvement may be adequate for other medications, opiate prescribing requires more stringent evaluations and documentation. It does appear side effects and issues of long term use of opiates have been discussed at some of patient's office visits, but the records are so degraded that the details are not clear. Also, included in the records for review, were 3 urine toxicology reports, mostly illegible: One from September 2015 and one from June 2015 both showing negative for Benzodiazepines which she was prescribed, and positive for Tricyclic Antidepressant which are not listed as prescribed for patient. The records available for review did not address the inconsistent urine toxicology results, at least not such that it was legible. Without objective assessment that patient has improved with regard to function with the opioids, and with evidence of possible non-adherence and/or diversion of other controlled substance, the Percocet refill request is not medically indicated.