

Case Number:	CM15-0210998		
Date Assigned:	10/29/2015	Date of Injury:	01/23/2013
Decision Date:	12/28/2015	UR Denial Date:	10/15/2015
Priority:	Standard	Application Received:	10/26/2015

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: New York

Certification(s)/Specialty: Anesthesiology

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 47 year old male, who sustained an industrial injury on 01-23-2013. The injured worker is currently not working. Medical records indicated that the injured worker is undergoing treatment for knee sprain-strain, enthesopathy of knee, and pain in lower leg joint. Treatment and diagnostics to date has included left knee MRI, aqua therapy, use of left knee brace, TENS (Transcutaneous Electrical Nerve Stimulation) Unit, cognitive behavioral therapy, and use of medications. Recent medications have included MS Contin, Furosemide, Albuterol, Allopurinol, Amlodipine, Cetirizine, Fluticasone spray, insulin, Losartan, Ondansetron, Pepcid, Qvar, Amitriptyline, Percocet, and Zolpidem. Subjective data (08-04-2015 and 09-14-2015), included left knee joint pain rated 5 out of 10. Objective findings (09-14-2015) included tenderness to palpation over the medial joint line to bilateral knees with positive McMurray's test. The request for authorization dated 10-12-2015 requested Percocet 10-325mg 1 tablet by mouth three times daily #90, MS Contin 30mg ER one by mouth three times daily #90, Elavil 25mg 1 tablet by mouth at bedtime #30, and Topamax 100mg 1 tablet by mouth at bedtime #30. The Utilization Review with a decision date of 10-15-2015 non-certified the request for Percocet 10-325mg #90, MS Contin 30mg ER #90, Elavil 25mg #30, and Topamax 100mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg 1 Tab Po Tid # 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and the ODG, Percocet (Oxycodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. In addition, the MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is lack of documentation of objective functional improvement with the use of Percocet. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

MS Contin 30 mg ER #90: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to ODG, chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. When these drugs do not satisfactorily reduce pain, opioids for moderate to severe pain may be added. According to ODG and MTUS, MS Contin (Morphine Sulfate Controlled-Release) is a controlled-release preparation that should be reserved for patients with chronic pain, who are in need of continuous treatment. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. For opioids, such as MS Contin, to be supported for longer than 6 months, there must be documentation of decreased pain levels and functional improvement. A satisfactory response to treatment may be indicated by decreased pain, increased level of function, and/or improved quality of life. In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS

guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. There is no documentation of significant pain relief or increased functional benefit from the opioids used to date. In addition, there is no indication as to why this patient requires MS Contin in addition to Percocet. Medical necessity of the requested medication has not been established. Of note, discontinuation of MS Contin should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Elavil 25MG #30: Upheld

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

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

Decision rationale: According to the ODG, tricyclic antidepressants, such as Amitriptyline (Elavil) are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclic antidepressants are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. The optimal duration of treatment is not known because most double-blind trials have been of short duration (6-12 weeks). It has been suggested that if pain is in remission for 3-6 months, a gradual tapering of anti-depressants may be undertaken. In this case, there is no documentation of objective evidence of functional benefit to support the subjectively reported improvement. Medical necessity for the requested medication has not been established. The medication is not medically necessary.

Topamax 100 mg #30: Upheld

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 based on Non-MTUS Citation Official Disability Guidelines (ODG) AEDs.

Decision rationale: Topiramate (Topamax) is an anticonvulsant (antiepilepsy) drug (AED). According to the CA MTUS and the ODG, AED's are recommended for neuropathic pain. There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at post herpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy

being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy. The choice of specific agents depends on the balance between effectiveness and adverse reactions. The guidelines cite the role of AEDs in the management of non-acute pain and chronic conditions such as, polyneuropathy, post-herpetic neuralgia, central pain, spinal cord injury, postoperative pain, migraine headaches, and chronic non-specific axial low back. Topiramate has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail. In addition, among the pharmacological treatments for PTSD, there is evidence of moderate strength supporting the efficacy of Topiramate for improving PTSD symptoms. In this case, there is no documentation of objective evidence of functional benefit to support the subjectively reported improvement. Medical necessity for Topiramate has not been established. The requested medication is not medically necessary.