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| Case Number: | CM15-0043654 | | |
| Date Assigned: | 03/16/2015 | Date of Injury: | 11/14/2006 |
| Decision Date: | 04/23/2015 | UR Denial Date: | 02/26/2015 |
| Priority: | Standard | Application Received: | 03/09/2015 |

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: Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

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 59 year old female, who sustained an industrial injury on November 14, 2006. The injured worker was diagnosed as having lumbar degenerative disc disease (DDD), lumbar thoracic radiculopathy, insomnia and depression. Treatment and diagnostic studies to date have included medications, nissen and cauterization procedures for bleeding due to gastrointestinal (GI) problems. A progress note dated January 14, 2015 the injured worker complains of low back pain that is constant and radiates to left hip and leg. Pain is rated 10/10 at worst and 7/10 on average. It is adversely affected by activity and weather and helped by heat. She also reports weakness, anxiety, depression, and sleep disturbance. It is noted she is considered a candidate for lumbar fusion because of the high risk of opioid misuse and gastric upset from the use of NSAIDs. Physical exam notes tenderness of lumbar region, decreased sensation over the left L4 and L5 nerve roots, tender taut muscles and motor weakness in both legs. The medications listed are Lidoderm, Paxil, Soma, Xanax, Morphine, Percocet and Gabapentin. A Utilization Review determination was rendered recommending non certification for Morphine 30mg #60, Percocet 10/325mg #120 and Gabapentin 300mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Morphine Controlled Release 30mg quantity 60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list; Opioids, Criteria for use; Weaning of Medications Page(s): 92-93; 78-80; 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 42-43, 74-96, 124. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Opioids.

Decision rationale: The CA MTUS and the ODG guidelines recommend that opioids can be utilized for the treatment of severe musculoskeletal pain when conservative treatments with NSAIDs, PT and surgeries have failed. The chronic use of opioids can be associated with the development of tolerance, dependency, sedation, addiction and adverse interaction with other sedative agents. The records indicate the patient could not tolerate NSAIDs because of a history of significant gastrointestinal disease. There is no documentation of guidelines required compliance monitoring with UDS, absence of aberrant behaviors and functional restoration. There is no documentation of failure of treatment with co-analgesics such as anticonvulsants medications. The patient is utilizing multiple sedative and psychiatric medications concurrently. The guidelines the criteria for the use of Morphine 30mg #60 were met.

Percocet 10/325mg quantity 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list; Opioids, Criteria for use; Weaning of Medications Page(s): 92-93; 78-80; 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 42-43, 74-96, 124. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Opioids.

Decision rationale: The CA MTUS and the ODG guidelines recommend that opioids can be utilized for the treatment of severe musculoskeletal pain when conservative treatments with NSAIDs, PT and surgeries have failed. The chronic use of opioids can be associated with the development of tolerance, dependency, sedation, addiction and adverse interaction with other sedative agents. The records indicate the patient could not tolerate NSAIDs because of a history of significant gastrointestinal disease. There is no documentation of guidelines required compliance monitoring with UDS, absence of aberrant behaviors and functional restoration. The patient is utilizing multiple sedative and psychiatric medications concurrently. The guidelines recommend minimal percentage of the total opioid requirement be utilized as breakthrough. The daily high dosage of Percocet utilization exceeds the requirement of breakthrough analgesic use. The criteria for the use of Percocet 10/325mg #120 were not met. Therefore the request is not medically necessary.

Gabapentin 300mg quantity 90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 16-22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Anticonvulsant.

Decision rationale: The CA MTUS and the ODG guidelines recommend that anticonvulsant medications can be utilized for the treatment of neuropathic pain and chronic pain syndrome associated with psychosomatic symptoms the records indicate that the patient had subjective, objective and radiological findings consistent with lumbar radiculopathy and chronic pain syndrome. There is documentation of functional restoration and efficacy with the use of gabapentin. The criteria for the use of Gabapentin 300mg #90 was met, and is medically necessary.