

Case Number:	CM15-0076525		
Date Assigned:	04/28/2015	Date of Injury:	12/01/2008
Decision Date:	08/03/2015	UR Denial Date:	04/03/2015
Priority:	Standard	Application Received:	04/21/2015

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: Internal Medicine

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 50 year old, male who sustained a work related injury on 12/1/08. The diagnoses have included cervical sprain/strain, cervical radiculitis, thoracic sprain/strain, lumbar strain/sprain, and lumbosacral or thoracic neuritis/radiculitis. The treatments have included MRIs, medications, a home exercise program, heat/ice and TENS unit therapy. In the PR-2 dated 2/26/15, the injured worker complains of constant, deep neck pain. He has pain that radiates down right arm to hand with numbness and tingling. He complains of intermittent mid back pain. He complains of constant low back pain. He has occasional radiating pain down both legs with pressure, shooting pain with numbness and tingling to feet. He rates his pain a 4/10 with treatments and an 8/10 without them. The treatment plan is refills of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 300mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-epilepsy/anti-convulsant drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-20, 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--Gabapentin (Neurontin).

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which 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. The records documented that this injured worker has chronic pain. Neurontin has been part of her medical regimen. However, there is no documentation of subjective or objective findings consistent with improvement of pain to necessitate use of Neurontin. Also Medical Records do not show that previous use of this medication has been effective in this injured worker for maintaining any functional improvement. Medical necessity for Neurontin has not been established.

Gabapentin 300mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-epilepsy/anti-convulsant drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-20, 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--Gabapentin (Neurontin).

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which 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. The records documented that this injured worker has chronic pain. Neurontin has been part of his medical regimen. However, there is no documentation of subjective or objective findings consistent with improvement of pain to necessitate use of Neurontin. Also Medical Records do not show that previous use of this medication has been effective in this injured worker for maintaining any functional improvement. Medical necessity for Neurontin has not been established.

Lidopro ointment 121g #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topicals Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example,

NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least one non-recommended drug (or drug class) is not recommended for use. In this case, the requested topical analgesic compound, LidoPro cream, contains: Capsaicin, Lidocaine, Menthol and Methyl Salicylate. MTUS guidelines state that Lidocaine is not recommended for topical application for treatment of neuropathic pain. Capsaicin is recommended only as an option in patients who have not responded to or are intolerant to other treatments. Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) is FDA approved for neuropathic pain, and used off-label for diabetic neuropathy. No other Lidocaine topical creams or lotions are indicated for neuropathic or non-neuropathic pain. Medical necessity for the requested topical analgesic compound has not been established. The requested topical compound is not medically necessary.

Percocet 5/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--Opioids.

Decision rationale: According to the CA MTUS and ODG, Percocet 5/325mg (Oxycodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately 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 no documentation of the medication's pain relief effectiveness, functional improvement from previous usage. Medical necessity of the requested item 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.

Zoloft 200mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Amitriptyline: anti-depressants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SSRIs (selective serotonin reuptake inhibitors) Page(s): 107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental & Stress Chapter.

Decision rationale: As per ODG-The American Psychiatric Association's diagnostic manual (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition -Text Revision. Washington, D.C., American Psychiatric Association, 2000) defines Major Depressive Disorder as a mental illness that is characterized by one or more Major Depressive Episodes without a history of Manic, Mixed, or Hypomanic Episodes (some details

that will help to provide an understanding of what this definition means are provided below). (American Psychiatric Association, 2000) This mental illness is typically manifested in phases, the person is mentally ill for a period of time, and is then typically free from the symptoms of the mental illness for a period of time, but will probably develop additional episodes of symptoms in the future. The "major depressive episodes" to which the above definition refers are the phases when the symptoms are present. These episodes are defined as: (1) a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities; (2) the individual also experiences at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep disturbance, psychomotor agitation or psychomotor retardation, decreased energy, feelings of worthlessness or guilt, difficulty thinking/concentrating/making decisions, recurrent thoughts of death or suicidal ideation/plans/attempts; & (3) the symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks. As per MTUS-Sertraline is not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. Selective serotonin reuptake inhibitors (SSRIs), a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline, are controversial based on controlled trials. It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. There is no compelling evidence presented by the treating provider that indicates this injured worker has had any significant improvements from this medication, and also review of Medical Records do not clarify that previous use of this medication has been effective in this injured worker for maintaining any functional improvement. Based on the currently available information, the medical necessity for this requested item has not been established. The requested treatment is not medically necessary. Of note, discontinuation of medicine should include a taper, to avoid withdrawal symptoms, weaning is typically recommended.

Baclofen 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-65. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter --Muscle relaxants.

Decision rationale: The California MTUS Guidelines and the ODG recommends non-sedating muscle relaxants, such as Baclofen, with caution as a second-line option for short-term treatment of acute low back pain(LBP), and for short-term (<2 weeks) treatment of acute exacerbations in patients with chronic LBP. The mechanism of action is blockade of the pre- and post-synaptic GABA receptors. It is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. It is also a first-line option for the treatment of dystonia. Baclofen has been noted to have benefits for treating lancinating, paroxysmal neuropathic pain. In this case, there is no documentation that this injured worker has maintained increase in function, or decrease in pain or spasm with the use of Baclofen. The duration of Baclofen use has far exceeded the guideline criteria (of 2-3 weeks). Medical necessity for the requested muscle relaxant has not been established. The requested medication is not medically necessary. Of note, discontinuation of Baclofen should include a taper, to avoid withdrawal symptoms, weaning is typically recommended.