

Case Number:	CM14-0122167		
Date Assigned:	08/08/2014	Date of Injury:	01/04/2001
Decision Date:	10/20/2014	UR Denial Date:	07/16/2014
Priority:	Standard	Application Received:	08/01/2014

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 56 year old male who had a work related injury on 01/04/01. The mechanism of injury is not described. He recently had a laminectomy in 2006. He went on to severe spinal stenosis and required a global L4-5 and L5-S1 decompression, fusion, and instrumentation on 12/10/08. He did fairly well for several years. In October of 2012, he had an MRI and CT scan which showed evidence of spinal stenosis at L3-4. Plain x-rays show a retrolisthesis of L3 on L4. He was involved in chronic pain management and had an epidural steroid injection which provided several months of significant pain relief. The most recent documentation submitted for review is dated 07/24/14. The injured worker rates his pain with medications as 7. Without medications it is a 10. He reports no new problems or side effects. Quality of sleep is poor; activity level has remained the same. Physical examination lumbar spine revealed surgical scars. Range of motion is restricted with flexion limited to 70 degrees and extension limited to 12 degrees limited by pain. Lumbar facet loading is positive on both sides. Straight leg raising test is positive on the left side and sitting at 80 degrees. Inspection of the left knee joint reveals surgical scar. No limitations are noted in flexion, extension, internal rotation, or external rotation. Crepitus is not noted with active movement but some clicking from the total knee replacement noted. Tenderness to palpation is noted over the medial joint line and patella. There is 1+ effusion of the left knee joint. Strength in the right EHL is rated 5/5, left EHL is rated 4/5. Light touch sensation is decreased over the L5 lower extremity dermatomes on the left side and the L4 lower extremity dermatomes on both sides. Absent ankle and absent knee jerks bilaterally. Diagnoses include post-laminectomy syndrome, lumbar radiculopathy, and lumbar facet syndrome. Prior utilization review on 07/06/14 was non-certified. Current request is for Gabapentin 300mg #120, Duloxetine DR 60mg #30, Pennsaid 1.5% solution, Ibuprofen 600mg #90, Famotidine 40mg #30, and 1 urine drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 300 mg, #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs); Gabapentin (Neurontin, Gabarone, generi.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 49.

Decision rationale: Current guidelines recommend Gabapentin for the treatment of neuropathic pain. The clinical documentation establishes the presence of objective findings consistent with neuropathy. As such, the continued use of Gabapentin is appropriate and medically necessary.

Duloxetine HCL DR 60 mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cymbalta; Non-neuropathic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Specific Antidepressants Page(s): 15.

Decision rationale: The request for Duloxetine HCL DR 60 mg, #30 is not medically necessary. The clinical documentation submitted for review does not support the request. The injured worker has been on this medication for 2 years and there has been no improvement in his pain or depression. As such medical necessity has not been established.

Pennsaid 1.5% solution, #1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel (Diclofenac) Page(s): 112.

Decision rationale: As noted on page 112 of the Chronic Pain Medical Treatment Guidelines, Voltaren Gel (Diclofenac) is not recommended as a first-line treatment. Diclofenac is recommended for osteoarthritis after failure of an oral NSAID, contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with Diclofenac, including topical formulations. According to FDA MedWatch, post-marketing surveillance of Diclofenac has reported cases of severe hepatic reactions, including liver necrosis, jaundice, fulminant hepatitis with and without jaundice, and liver failure. With the lack of data to support superiority of Diclofenac over other NSAIDs and the possible increased hepatic and cardiovascular risk associated with its use, alternative

analgesics and/or non-pharmacological therapy should be considered. As such the request for this medication cannot be recommended as medically necessary at this time.

Ibuprofen 600 mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 70.

Decision rationale: As noted on page 70 of the Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended as a second-line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute lower back pain. Additionally, it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. Further, there is no indication the patient cannot utilize the readily available formulation and similar dosage of this medication when required on an as needed basis. As such, the request for Motrin 600mg #90 cannot be established as medically necessary.

Famotidine 40 mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk; Proton pump inhibitors.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Online Version, Integrated Treatment/Disability Duration Guidelines, Pain (Chronic), Proton pump inhibitors (PPIs)

Decision rationale: As noted in the Official Disability Guidelines - Online version, Pain Chapter, proton pump inhibitors are indicated for patients at intermediate and high risk for gastrointestinal events with concurrent use of non-steroidal anti-inflammatory drug use. Risk factors for gastrointestinal events include age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). There is no indication that the patient is at risk for gastrointestinal events requiring the use of proton pump inhibitors. Furthermore, long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. As such, the request for this medication cannot be established as medically necessary.

One urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Substance abuse (tolerance, dependence, addition). Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

Decision rationale: As noted on page 43 of the Chronic Pain Medical Treatment Guidelines drug testing is recommended as an option. It is noted that using a urine drug screen to assess for the use or the presence of illegal drugs is an option. Urine drug screens are recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. The test should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. Patients at "high risk" of adverse outcomes may require testing as often as once per month. As such, the request for urine drug test is not medically necessary.