

Case Number:	CM14-0142245		
Date Assigned:	09/10/2014	Date of Injury:	04/04/2007
Decision Date:	10/10/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	09/02/2014

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 Occupational 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 claimant was injured on 04/04/07 while pulling a sofa from under a storage rack. Gabapentin, cyclobenzaprine, hydrocodone-APAP, Voltaren, and methadone are under review. He has had physical therapy and thoracic spine epidural steroid injections with temporary relief. He also had facet injections of the low back. The claimant has multiple diagnoses including chronic pain with lumbar facet arthropathy, bilateral ischial bursitis, anxiety and dysthymic disorder, drug dependence, insomnia, sacroiliitis, kyphosis, gait instability, abnormal posture, and edema. He was evaluated on 03/18/14 by [REDACTED] and reported ongoing aching, burning, cramping, and shooting pain. The pain was worse in his low back than his leg. He had difficulty with his activities. He was on modified duty. He had been prescribed Norco and was taking it regularly as prescribed with significant pain relief including being able to do his activities of daily living. He was taking methadone 3 times daily. He reported functional improvement with the medications. He was prescribed Neurontin, Pamelor, Protonix, Flexeril, hydrocodone-APAP, and Voltaren. An MRI of the lumbar spine in 2007 revealed fusion of the lower thoracic spine and mild facet degenerative changes and disc desiccation at L3-4 with a disc bulge but no spinal stenosis or neural foraminal narrowing. At L4-5 there were mild facet degenerative changes and ligamentum flavum hypertrophy with mild disc desiccation and no disc protrusion or extrusion. There is minimal spinal stenosis with no neural foraminal narrowing. At L5-S1 there were mild facet degenerative changes and mild disc desiccation with a posterior disc bulge with no spinal stenosis or neural foramen narrowing. He was in no distress and was able to sit comfortably on the exam table without difficulty. He had an analgesic gait that was slow and he used a cane. He had tenderness, trigger points, and spasm in his back with decreased range of motion. Leg raises were moderately positive bilaterally for radicular symptomatology and he had significant diminished sensation along the bilateral L5 and S1 root distributions and mild weakness of ankle

dorsiflexion and plantar flexion and EHL on the right side and decreased ankle plantar flexion and extensor hallucis longus on the left side. He had trace diminished reflexes at the patellae. He was still experiencing frequent tripping and cramping of the bilateral lower extremities and a new MRI was ordered. Overall he was unchanged. He was advised on home exercises and anti-inflammatory medications. He reportedly was on chronic stable doses of narcotics and methadone. A drug screen dated 02/19/14 revealed evidence of THC, hydrocodone, methadone, gabapentin, nortriptyline, cyclobenzaprine. Of note, on 02/15/13, THC was also noted in a urine drug screen report and it is not clear whether these findings were addressed with the claimant at that time. He had a panel QME on 03/11/14. An MRI had shown multilevel degenerative changes of the cervical spine. He also had significant degenerative changes in the thoracic spine and non-verifiable radicular complaints involving the low back. MRI showed multilevel degenerative changes. On 04/29/14, he continued to report pain. There is brief mention that the results of the drug screen were discussed with him, including noncompliance with the opioid policy. On 05/27/14, he was seen again. On 07/03/14, it appeared that he had more pain in his legs. He continued his same medication. On 08/04/14, it appears that he was status quo. He continued the same medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 600 mg, #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin, Anti-epilepsy drugs, Medications for Chronic Pain, Page(s): 83, 46, 94.

Decision rationale: The history and documentation do not objectively support the request for continued use of gabapentin 600 mg #90. The MTUS state "gabapentin (Neurontin) is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." Also, MTUS states "anti-epilepsy drugs (AEDs) are also referred to as anti-convulsants. Recommended for neuropathic pain (pain due to nerve damage. (Gilron, 2006) (Wolfe, 2004) (Washington, 2005) (ICSI, 2005) (Wiffen-Cochrane, 2005) (Attal, 2006) (Wiffen-Cochrane, 2007) (Gilron, 2007) (ICSI, 2007) (Finnerup, 2007) 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 postherpetic 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. (Attal, 2006) The choice of specific agents reviewed below will depend on the balance between effectiveness and adverse reactions." Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain

unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medication should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within one week. A record of pain and function with the medication should be recorded. (Mens 2005) In this case, there is no clear evidence of neuropathic pain. No focal neurologic deficits have been described and the claimant has primarily soft tissue musculoskeletal complaints, including tenderness and spasms. The MRI did not reveal nerve root compression. No EMG/NCV were reported. There is no evidence of diabetic neuropathy or postherpetic neuralgia. There is no evidence of trials of other first line medications for pain including acetaminophen and NSAIDs, which have failed to provide relief. There is also no evidence that the claimant has tried local modalities or has been involved in an ongoing exercise program to help maintain any benefits he gets from treatment modalities. The medical necessity of this request for gabapentin 600 mg #90 has not been clearly demonstrated.

Cyclobenzaprine HCL 7.5 mg, #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, page 74; Medications for Chronic Pain, page 94 Page(s): 74, 94.

Decision rationale: The history and documentation do not objectively support the request for continued use of cyclobenzaprine HCl 7.5 mg #60. The MTUS state for cyclobenzaprine (Flexeril), "Recommended as an option, using a short course of therapy. The effect is greatest in the first four days of treatment, suggesting that shorter courses may be better. (Browning, 2001). Treatment should be brief." Additionally, MTUS and ODG state "relief of pain with the use of medications is generally temporary and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medication should show effects within 1 to 3 days, ... A record of pain and function with the medication should be recorded. (Mens 2005) Uptodate for "Flexeril" also recommends "do not use longer than 2-3 weeks" and is for "short-term (2-3 weeks) use for muscle spasm associated with acute painful musculoskeletal conditions." The medical documentation provided does not establish the need for long-term/chronic usage of Flexeril, which MTUS guidelines advise against. The claimant has had spasm noted on examination, but his pattern of use of medications, including other first-line drugs such as acetaminophen and anti-inflammatories and the response to them, including relief of symptoms and documentation of functional improvement, have not been described. There is no indication that he has been involved in an ongoing exercise program, including stretching, to try to control spasms and to maintain the benefits of his treatment. As such, this request for cyclobenzaprine hydrochloride 7.5 mg #60 is not medically necessary.

Hydrocodone-APAP 10/325 mg, #120: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for Chronic Pain, Medications for Chronic Pain, Page(s): 110, 94.

Decision rationale: The history and documentation do not objectively support the request for the opioid hydrocodone-APAP 10/325mg #120. The MTUS outlines several components of initiating and continuing opioid treatment and states "a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." In these records, there is no documentation of trials and subsequent failure of or intolerance to first-line drugs such as acetaminophen or nonsteroidal anti-inflammatory drugs. MTUS further explains, "pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts." There is also no indication that periodic monitoring of the claimant's pattern of use and a response to this medication, including assessment of pain relief and functional benefit, has been or will be done. There is no evidence that he has been involved in an ongoing rehab program to help maintain any benefits he receives from treatment measures. Additionally, the 4A's "analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors" should be followed and documented per the guidelines. There is evidence that a signed pain agreement is on file at the provider's office and this was referred to. However, two urine drug tests revealed the presence of THC and this was addressed after the 02/14 drug screen but it is not clear whether the same result noted in 02/13 was addressed. This would indicate that the claimant was found to be noncompliant with his opioid agreement on two occasions but it is not clear whether his drug use has been appropriately addressed. There is no evidence that a pain diary has been recommended and is being kept by the claimant and reviewed by the prescriber. As such, the medical necessity of the ongoing use of hydrocodone-APAP 10/325 mg #120 has not been clearly demonstrated.

Voltaren XR 100 mg, #60: 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 Anti-Inflammatory medications, Page(s): 102.

Decision rationale: The history and documentation do not objectively support the request for continued use of Voltaren XR 100mg #60. The MTUS state re: NSAIDs "Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class

over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxen being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Back Pain -Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain." There is no evidence of osteoarthritis or that the claimant uses the medication for acute flare ups of chronic pain. His pattern of use of Voltaren XR is unknown. There is no evidence of ongoing significant inflammation to support the use of this type of medication on a chronic basis without evidence of trials of acetaminophen, local modalities, and a continuing exercise program. The medical necessity of the use of Voltaren XR 100mg has not been demonstrated.

Methadone HCL 10 mg, #90: 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 Methadone, Medications for Chronic Pain Page(s): 95, 94.

Decision rationale: The history and documentation do not objectively support the request for methadone 10 mg #90. The MTUS states "Methadone is recommended as a second-line drug for moderate to severe pain if the potential benefit outweighs the risk. The FDA reports that they have received reports of severe morbidity and mortality with this medication. This appears, in part, secondary to the long half-life of the drug (8-59 hours). Pain relief on the other hand only lasts from 4-8 hours. Methadone should only be prescribed by providers experienced in using it. (Clinical Pharmacology, 2008) Pharmacokinetics: Genetic differences appear to influence how an individual will respond to this medication. Following oral administration, significantly different blood concentrations may be obtained. Vigilance is suggested in treatment initiation, conversion from another opioid to methadone, and when titrating the methadone dose. (Weschules 2008) (Fredheim 2008) Adverse effects: Delayed adverse effects may occur due to methadone accumulation during chronic administration. Systemic toxicity is more likely to occur in patients previously exposed to high doses of opioids. This may be related to tolerance that develops related to the N-methyl-D-aspartate (NMDA) receptor antagonist. Patients may respond to lower doses of methadone than would be expected based on this antagonism. One severe side effect is respiratory depression (which persists longer than the analgesic effect). Methadone should be given with caution to patients with decreased respiratory reserve (asthma, COPD, sleep apnea, severe obesity). QT prolongation with resultant serious arrhythmia has also been noted. Use methadone carefully in patients with cardiac hypertrophy and in patients at risk for hypokalemia (including those patients on diuretics). Methadone does have the potential for abuse. Precautions are necessary as well for employees in safety sensitive positions, including

operation of a motor vehicle."Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medication should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within one week. A record of pain and function with the medication should be recorded. (Mens 2005) MTUS outlines several components of initiating and continuing opioid treatment and states "a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." In these records, there is no documentation of trials and subsequent failure of or intolerance to first-line drugs such as acetaminophen or nonsteroidal anti-inflammatory drugs. MTUS further explains, "pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts." There is no evidence that he has been involved in an ongoing rehab program to help maintain any benefits he receives from treatment measures. Additionally, the 4A's "analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors" should be followed and documented per the guidelines. There is evidence that a signed pain agreement is on file at the provider's office and this was referred to. However, two urine drug tests revealed the presence of THC and this was addressed after the 02/14 drug screen but it is not clear whether the same result noted in 02/13 was addressed. This would indicate that the claimant was found to be noncompliant with his opioid agreement on two occasions but it is not clear whether his drug use has been appropriately addressed. There is no evidence that a pain diary has been recommended and is being kept by the claimant and reviewed by the prescriber. As such, the medical necessity of the ongoing use of Methadone 10mg #90 has not been clearly demonstrated.