

Case Number:	CM14-0211135		
Date Assigned:	12/24/2014	Date of Injury:	04/28/2006
Decision Date:	02/20/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	12/16/2014

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. 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: Colorado

Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

66 year old female with date of injury 4/28/2006 continues care with treating physician. Patient complaints include chronic low back pain radiating to the legs, left knee pain and fibromyalgia. She follows a home exercise program and takes medications including Oxycodone, Gabapentin, Effexor, and Prednisone with some relief of pain. Patient pain ratings are stable over time, per the records, rated 9/10 with no medications and 4/10 with aforementioned medication regimen. The treating physician requests Aquatic Therapy, Oxycodone refill, Gabapentin refill, and Urine Drug Screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Aquatic Therapy Treatments: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 22 and 99.

Decision rationale: Per the guidelines, Aquatic therapy is recommended as an alternative to land-based physical therapy, specifically where decreased weight bearing is needed or recommended, for example in obesity. The number of recommended supervised sessions for aquatic therapy is the same as those recommended for land-based therapy: For myalgia and myositis 9-10 visits recommended over 8 weeks and for neuralgia, neuritis, and radiculitis, 8-10 visits recommended over 4 weeks. For the patient of concern, the treating physician indicates in the record that limited weight bearing would be desirable, though he does not clarify why. (Decreased weight bearing would likely be desirable because of patient's knee issues.) However, patient has been participating in home exercise program, land-based, with reported improvement, so no clear indication as to why aquatic therapy would be needed. Without clear need for Aquatic Therapy, and with history of improvement with home exercise program, the request for Aquatic Therapy is not medically necessary.

1 Urine Drug Screen: 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), Urine Drug Testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 78-79 and 85.

Decision rationale: Per the Guidelines, opioid use should be monitored, and there are tools recommended for that, including the 4 A's for Ongoing Monitoring: Analgesia, Adverse effects, Activities of Daily Living, and Aberrant behaviors. Urine drug screens negative for the substances prescribed would be indicators of possible aberrant behavior including noncompliance and diversion. Within the Guidelines, Chelminski defines "serious substance misuse" as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005) Furthermore, evidence of serious non-adherence warrants immediate discontinuation of opioids. For the patient of concern, all urine drug screens have been consistent, and there is no documented aberrant drug taking behavior. However, as opioid monitoring has not followed the guideline recommendations, opioids are no longer indicated, so no further urine drug screens would be indicated either. The request for Urine drug screen is not medically necessary.

1 Prescription of Oxycodone 5mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 79-80, 85, and 89-90.

Decision rationale: The Guidelines establish criteria for use of opioids, including long term use (6 months or more). When managing patients using long term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. (Information from sources other than patient can also be considered.) Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain / work / interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant / addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize the above, the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient. 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits "serious non-adherence / misuse" (including urine drug testing negative for prescribed substances on 2 occasions). Per the Guidelines, Chelminski defines "serious substance misuse" as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005). 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work? Has patient had improved function and decreased pain with the opioids? For the patient of concern, while the pain ratings do indicate improved levels of pain, there is no consistent objective documentation of functional improvement. (CURES report was reviewed on 1 visit, but there is no documentation of routine monitoring of functional improvement as recommended in the guidelines. Patient has not returned to work taking the Oxycodone. As the monitoring of opioid use for the patient of concern does not follow the guidelines, and functional improvement has not been consistently documented, therefore, the request for Oxycodone is not medically necessary.

1 Prescription for Gabapentin 100mg, #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drug (AEDs)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 16-19.

Decision rationale: Per the guidelines, Gabapentin, an anti-epileptic drug, is recommended for treatment of neuropathic pain, as is the class of anti-epilepsy drugs (AED's). These drugs have been most studied for treatment of post herpetic neuralgia and diabetic neuropathy. Because neuropathic pain is often multifactorial with variable symptoms and physical findings, there is a lack of agreement among experts on the best treatment. There is also a lack of quality evidence for any specific treatment for neuropathic pain with most randomized control trials addressing the above mentioned post-herpetic neuralgia and other polyneuropathies, and few randomized control trials for central pain, none for treatment of radicular pain. As there is a lack of good evidence / expert agreement, per the guidelines, the choice of a specific agent for treatment of neuropathic pain and the decision to continue treatment with a specific anti-epileptic drug are generally determined by efficacy of the medication and any adverse reactions experienced. When using anti-epileptic drugs for treatment of neuropathic pain, the guidelines define a "good" response to the use of AEDs...as a 50% reduction in pain and a "moderate" response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" for the following: (1) a switch to a different first-line agent (2) combination therapy if treatment with a single drug agent fails.(Eisenberg, 2007) (Jensen, 2006). Per the guidelines, patient pain levels and functional improvement while taking medications should be documented at follow up appointments. Gabapentin specifically has good evidence to support its use, first-line, in neuropathic pain. (Backonja, 2002) (ICSI, 2007) (Knotkova, 2007)(Eisenberg, 2007) (Attal, 2006) It is FDA-approved for use in post-herpetic neuralgia. In addition to use in neuropathic pain, Gabapentin has evidence to support its use in spinal stenosis, fibromyalgia, spinal cord injury, and some evidence to support its use in post-operative pain to decrease anxiety and need for opioids. For the patient of concern, the records indicate that generally patient's pain is at least 30% improved, and often 50% improved. (Most recent office visit note does indicate a spike in pain, but overall, well controlled on current regimen which includes Gabapentin) The records indicate function improved, though activities of daily living are persistently noted as "limited." As patient has been taking Gabapentin and has fairly consistently maintained improved pain and function, the Gabapentin is medically necessary.