

Case Number:	CM15-0016872		
Date Assigned:	02/05/2015	Date of Injury:	07/31/2013
Decision Date:	03/27/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	01/29/2015

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: TR, California, Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational 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 58 year old female who sustained an industrial injury on 07/31/13. She reports low back pain. Treatments to date include medications. The diagnosis includes cervical spine spondylosis. The treating physician notes from 01/17/15 are mostly illegible. The treatment plan includes Voltaren gel, Neurontin, Tylenol #3, and Prilosec. On 01/26/15 Utilization Review non-certified the Tylenol #3, Neurontin, Prilosec, and Voltaren gel, citing MTUS guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 Tylenol #3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: Chronic use of opioids is addressed thoroughly by the MTUS chronic pain guidelines and given the long history of pain treatment in this patient since the initial date of injury (7/31/13), consideration of the MTUS Criteria for Use of Opioids in chronic pain is appropriate. Documentation of pain and functional improvement are critical components, along with documentation of adverse effects. While the MTUS does not specifically detail a set visit frequency for re-evaluation, recommended duration between visits is 1 to 6 months. In this case, the patient clearly has a multitude of concerns warranting close monitoring and treatment, to include close follow up regarding improvement in pain/function; consideration of additional expertise in pain management should be considered if there is no evidence of improvement in the long term. More detailed consideration of long-term treatment goals for pain (specifically aimed at decreased need for opioids), and further elaboration on dosing expectations in this case would be valuable. More detailed expectations should be outlined with the patient regarding the treatment plan and follow up plans working to decrease opioid dependency is recommended. Consideration of other pain treatment modalities and adjuvants is also recommended. Given the lack of details regarding plans for weaning, potential adverse effects noted (dizziness, per records), and lack of functional improvement in light of the chronic nature of this case, the request for Tylenol #3 is not considered medically necessary.

Voltaren Gel 1.7 Percent #2 100 Gram: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The MTUS lists Voltaren Gel as an FDA approved medication indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip, or shoulder. The patient has been treated for several months with topical Voltaren and with no evidence of functional improvement coupled with the lack of evidence for use in the surface regions of this patient's complaints, the request can not be considered medically necessary.

60 Neurontin 300 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 16-22.

Decision rationale: Anti-epilepsy medications like Neurontin (Gabapentin - generic) are recommended for neuropathic pain, but if a 30% pain reduction is not produced from a trial consisting of three to eight weeks for titration and 1-2 weeks at maximum tolerated dose, changing pharmacologic treatment plans is recommended. With no improvement in objective findings (and a pain level reportedly decreasing from 6/10 to 5/10) during a trial of Neurontin

from 9/22/14 - 12/5/14, findings do not support functional improvement. The patient continues to have neuropathic pain on exam without evidence in the provided documents of significant improvement in pain, which makes continued use difficult to justify based on the guidelines. Therefore the request for Neurontin cannot be considered medically necessary based on the provided record. Similarly, the retrospective request for Gabapentin dispensed on 1/7/15 is also not considered medically necessary based on the provided records and guidelines.

90 Gabapentin 300 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 16-22.

Decision rationale: Anti-epilepsy medications like Neurontin (Gabapentin - generic) are recommended for neuropathic pain, but if a 30% pain reduction is not produced from a trial consisting of three to eight weeks for titration and 1-2 weeks at maximum tolerated dose, changing pharmacological treatment plans is recommended. With no improvement in objective findings (and a pain level reportedly decreasing from 6/10 to 5/10) during a trial of Neurontin from 9/22/14 - 12/5/14, findings do not support functional improvement. The patient continues to have neuropathic pain on exam without evidence in the provided documents of significant improvement in pain, which makes continued use difficult to justify based on the guidelines. Therefore the request for Neurontin cannot be considered medically necessary based on the provided record. Similarly, the retrospective request for Gabapentin dispensed on 1/7/15 is also not considered medically necessary based on the provided records and guidelines.

30 Prilosec 20 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68-69.

Decision rationale: The MTUS recommends consideration of non-selective NSAIDs with a proton pump inhibitor or a Cox-2 inhibitor like Celebrex in patients at intermediate risk for gastrointestinal events and no cardiovascular disease. Prior prospective requests for Celebrex were noted to be non-certified by utilization review due to GI complaints and the patient was not taking NSAIDs at the time of requested dispensation per the provided records, therefore, the request for Prilosec cannot be considered medically necessary per the guidelines.