

Case Number:	CM15-0115089		
Date Assigned:	06/23/2015	Date of Injury:	09/30/1993
Decision Date:	07/29/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	06/15/2015

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: Emergency 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 62 year old male, who sustained an industrial injury on September 30, 1993. The injury occurred as a result of the injured workers usual customary duties as a strawberry picker. The injured worker has been treated for back, lower extremity and right shoulder complaints. The diagnoses have included lumbar radiculopathy, opioid tolerance, axial low back pain, lumbar degenerative disc disease, lumbar facet arthropathy, thoracic myofascial tenderness, right rotator cuff injury, right shoulder pain, insomnia and depressive disorder not elsewhere classified. Documented treatment to date has included medications, electrodiagnostic studies, psychological testing and a functional restoration program. Current documentation dated April 24, 2015 notes that the injured worker reported low back pain with radiation to the bilateral lower extremities, right leg greater than the left, which was new for the injured worker. Associated symptoms in the right lower extremity included a pins and needle sensation. The injured worker was noted to have had an exacerbation of low back pain since the prior visit. Examination of the thoracic spine revealed myofascial tenderness and significant trigger points with a twitch response in the gluteus medius and lumbar paraspinal muscles. The injured worker also noted right shoulder pain secondary to a rotator cuff injury. The treating physician's plan of care included requests for Celebrex 100 mg, # 60 with 4 refills, Trazadone 50 mg # 20 with 6 refills, Gabapentin 600 mg # 90 with 4 refills and Venlafaxine Hydrochloride 150 mg # 30 with 4 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celebrex 100mg, #60 with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 22, 30, 60, 67, 68.

Decision rationale: The medication Celebrex is a non-steroidal anti-inflammatory drug that is a COX-2 selective inhibitor. The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines for chronic low back pain recommends non-steroidal anti-inflammatory drugs as an option for short-term use to reduce pain so activity and functional restoration can resume. The long-term use of non-steroidal anti-inflammatory drugs is not without significant gastrointestinal, cardiovascular and renal risks. COX-2 inhibitors are recommended for patients with gastrointestinal problems and not for "the majority of other patients". Non-steroidal anti-inflammatory drugs are recommended for acute exacerbations of chronic low back pain as a second-line treatment after acetaminophen. Before prescribing medications for chronic pain, the following should occur: "determine the aim of the use of the medication; determine the potential benefits and adverse effects and determine the injured workers preference." "Only one medication should be given at a time and interventions that are active and passive should remain unchanged at the time of the medication change." The injured worker was noted to be receiving Celebrex for at least six months for chronic pain. There is no documentation regarding failure of first line analgesia such as acetaminophen or concerns of gastrointestinal problems. Additionally, documentation does not include significant pain relief or functional improvement noted with the continued use of the requested medication. Therefore, the request for Celebrex is not medically necessary.

Trazodone 50mg, #20 with 6 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain, tricyclic antidepressants Page(s): 13; 122.

Decision rationale: Trazadone is a tricyclic antidepressant. The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines recommend "anti-depressants as a first line option for neuropathic pain and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration and psychological assessment. Side effects include excessive sedation which should be assessed. It is recommended that these outcome

measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks." The occurrence of anxiety, depression and insomnia is frequent in injured workers with chronic pain. The IW has been taking this medication for a minimum of 1 year. The documentation does not report improvement of mental health, or pain with the use of Trazadone. There is no improvement of function documented nor is there is change in reliance on analgesic medications. Additionally, the request does not including dosing and frequency. Without the support of the guidelines, the request for Trazadone 50 mg # 20 with 6 refills is not medically necessary.

Gabapentin 600mg, #90 with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-18.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs Page(s): 16, 17, 18, 49.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state that 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. A recent review has indicated that there is insufficient evidence to recommend for or against antiepileptic drugs for axial low back pain. There is a lack of evidence to demonstrate that anti-epilepsy drugs significantly reduce the level of myofascial or other sources of somatic pain. These medications provide additional analgesia and reduce the dependence on opioids and other medications. It is unclear from the submitted documentation what ailment gabapentin was prescribed to treat. The IW did not have a diagnosis of neuropathic pain. The IW had been on this medication for a least one year. The records did not support the IW had improvement in pain symptoms with this medication nor did he have a decrease reliance on opiate medications. Furthermore, it is recommended that the provider evaluate the injured worker on a monthly basis to determine the necessity to continue the medication. This request is for 4 refills which exceeds the recommendation for monthly evaluations. The request for Gabapentin is not medically necessary.

Venlafaxine HCL (hydrochloride) 150mg, #30 with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants for chronic pain Page(s): 13, 123.

Decision rationale: CA MTUS chronic pain guidelines recommend Venlafaxine as a first line option for neuropathic pain. There is no documentation submitted for review that explains a supporting rationale for the prescribing of this medication. It is unclear if it is being utilized in the capacity of an anti-depressant or for chronic pain management. There is no documentation discussing the IW's current use of or effects from this medication. The request does not include dosing and frequency. Additionally, these medications should be prescribed with a monitoring program. The request for multiple refills is contrary to this recommendation. Without this information, the request cannot be supported and the request for Venlafaxine is considered not medically necessary.