

Case Number:	CM15-0115832		
Date Assigned:	06/24/2015	Date of Injury:	09/23/1997
Decision Date:	08/04/2015	UR Denial Date:	06/01/2015
Priority:	Standard	Application Received:	06/16/2015

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: Arizona, Michigan

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 71 year old male, who sustained an industrial injury on September 23, 1997. He reported sharp low back pain. The injured worker was diagnosed as having low back pain. Diagnostic studies to date have included MRIs and x-rays. On November 8, 2000, electrodiagnostic studies revealed lumbar 5-sacral 1 radiculopathy, right greater than left. On January 28, 2002, an MRI of the lumbar spine revealed long-standing disc degeneration at the lumbar 4-5 and lumbar 5-sacral 1 levels, with mild spondylosis, combined disc and annular bulging, and mild facet arthritis. There was no visible likely clinically significant mechanical impingement affecting any of the traversing or exiting nerve roots. There were so significant changes since the prior MRI in 1998. On May 12, 2014, a urine drug screen was performed. The results were negative for opiates, which is inconsistent with his prescribed medication regimen. Treatment to date has included physical therapy, massage therapy, a back brace, epidural steroid injections, Pilates, and medications including short-acting and long-acting opioid analgesics, topical analgesic, antidepressant, sleep, non-steroidal anti-inflammatory, and muscle relaxant. Other noted dates of injury documented in the medical record include: 1976 and 1980's. Comorbid diagnoses included history of elevated liver enzymes. On May 7, 2015, the injured worker complains of ongoing low back pain. The physical exam revealed decreased range of motion of the low back, tenderness, and slow movement due to pain. The treatment plan includes Oxycontin 20 mg twice a day, Oxycontin 10 mg twice a day, and Gabapentin 600 mg three times a day. Requested treatments include: Oxycontin 10 mg and Gabapentin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 10mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use: On-Going Management, When to Discontinue Opioids, When to Continue Opioids; Opioids for chronic pain; Opioids, long-term assessment; Opioids, specific drug list: Oxycodone immediate release (OxyIR capsule; Roxicodone tablets; generic available), Oxycodone controlled release (OxyContin) Page(s): 78-80; 88; 92.

Decision rationale: The long term usage of opioid therapy is discouraged by the California Medical Treatment Utilization Schedule (CMTUS) guidelines unless there is evidence of "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. 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. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." There was lack of physician documentation of the least reported pain over the period since last assessment, average pain, the intensity of pain after taking the opioid, how long it takes for pain relief, how long pain relief lasts, improvement in pain, and improvement in function. In addition, the California Medical Treatment Utilization Schedule (MTUS) guidelines details indications for discontinuing opioid medication, such as serious non-adherence or diversion. The records clearly indicate inconsistent urine drug test and the inconsistent results are not explained by treating provider, which would be necessary for continued usage. Therefore, the request for Oxycontin 10 mg is not medically necessary.

Gabapentin 600mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs); SPECIFIC ANTI-EPILEPSY DRUGS: Gabapentin (Neurontin, Gabarone generic available) Page(s): 16-19.

Decision rationale: The California Medical Treatment Utilization Schedule (CMTUS) guidelines recommend anti-epilepsy drugs (also referred to as anti-convulsants) as a first-line treatment for neuropathic pain (pain due to nerve damage). There are few randomized controlled trials directed at central pain and none for painful radiculopathy. Gabapentin 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. "The choice of specific agents will depend on the balance between effectiveness and adverse reactions. A

"good" response to the use of AEDs has been defined 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 (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects." A review of the injured workers medical records do not reveal documentation of pain and functional improvement as required by the guidelines for continued use, therefore the request for Gabapentin is not medically necessary.