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| Case Number: | CM15-0171627 | | |
| Date Assigned: | 09/11/2015 | Date of Injury: | 08/08/2001 |
| Decision Date: | 11/02/2015 | UR Denial Date: | 08/20/2015 |
| Priority: | Standard | Application Received: | 08/31/2015 |

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: Anesthesiology

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 56-year-old female with an industrial injury dated 08-08-2001. A review of the medical records indicates that the injured worker is undergoing treatment for cervical post laminectomy syndrome and thoracic post laminectomy syndrome, bilateral upper extremity radiculitis; diffuse regional myofascial pain, chronic pain syndrome with both sleep and severe mood disorder. Treatment consisted of diagnostic studies, two level cervical disc replacement surgery, thoracic laminectomy for spinal cord stimulator placement, greater than 6 to 8 cervical epidural steroid injection (ESI) without improvement of functionality, greater than 25 physical therapy, pain psychology, psychiatry, prescribed medications, and periodic follow up visits. In a progress note dated 04-10-2015, the injured worker continues to have pain ranging from 6-9 out of 10. Magnetic Resonance Imaging (MRI) scan of the cervical spine dated 03-30-2015 revealed no significant changes from the November 22, 2011 study. In a more recent progress note dated 08-10-2015, the injured worker reported low back pain and neck pain. Objective findings (08-10-2015) revealed slow and guarded gait, markedly limited cervical flexion, limited cervical extension, asymmetric shoulder girdles, marked loss of normal cervical lordosis, limited bilateral shoulder range of motion with pain radiating to neck and midback. Severe myofascial trigger points and spasm in the cervical paraspinal muscles, trapezius muscles, levator scapula and rhomboid musculature were also noted on exam. The treating physician reported that the injured worker has difficulty with activities of daily living. The treating physician also reported that the injured worker remains unable to compete in the open labor force. The treating physician prescribed services for 1 Prescription of Alprazolam 1mg #30 with 3 refills, 1 Prescription of Percocet 10-325mg #90, 1 Prescription of Rabeprazole 20mg #30 with 3 refills, 1 Prescription of Senna 8.6mg #60 with 3 refills, 1 Prescription of Topiramate 50mg #60 with 3 refills and 1 physical therapy referral, now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Alprazolam 1mg #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Benzodiazepines.

Decision rationale: Alprazolam (Xanax) is a short-acting benzodiazepine drug having anxiolytic, sedative, and hypnotic properties. The medication is used in conjunction with anti-depressants for the treatment of depression with anxiety, and panic attacks. Per California MTUS Guidelines, benzodiazepines are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Most guidelines limit use to four weeks. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

1 Prescription of Percocet 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and the ODG, Percocet (Oxycodone / Acetaminophen) is a short-acting opioid analgesic indicated for moderate to severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, objective functional improvement, or response to ongoing opioid analgesic therapy. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested treatment with Percocet 10/325 mg is not medically necessary.

1 Prescription of Rabeprazole 20mg #30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Proton Pump Inhibitors (PPIs).

Decision rationale: According to CA MTUS (2009), proton pump inhibitors (PPIs), such as Aciphex (Rabeprazole), are recommended for patients taking NSAIDs with documented GI

distress symptoms or specific GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. According to the ODG, a trial of omeprazole or lansoprazole had been recommended before prescription Nexium therapy (until it went OTC). Other PPIs, such as Aciphex, would be considered second-line. In this case, there is no documentation indicating the patient has any GI symptoms or GI risk factors. The medical necessity for Aciphex has not been established. The requested medication is not medically necessary.

1 Prescription of Senna 8.6mg #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: Opioid-induced constipation is a common adverse effect of long-term opioid use because of the binding of opioids to peripheral opioid receptors in the gastrointestinal tract, resulting in absorption of electrolytes and reduction in small intestine fluid. According to ODG, if opioids are determined to be appropriate for the treatment of pain then prophylactic treatment of constipation should be initiated. Senna is a stimulant laxative and is used to relieve occasional constipation. In this case, with non-approval of opioid use, the medical necessity of Senna is not established. The requested medication is not medically necessary.

1 Prescription of Topiramate 50mg #60 with 3 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) AEDs.

Decision rationale: Topiramate (Topamax) is an anticonvulsant (antiepilepsy) drug (AED). According to the CA MTUS and the ODG, AED's are recommended for neuropathic pain. 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. The choice of specific agents depends on the balance between effectiveness and adverse reactions. The guidelines cite the role of AEDs in the management of non-acute pain and chronic conditions such as, polyneuropathy, post-herpetic neuralgia, central pain, spinal cord injury, postoperative pain, migraine headaches, and chronic non-specific axial low back. Topiramate has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail. In addition, among the pharmacological treatments for PTSD, there is evidence of moderate strength supporting the efficacy of Topiramate for improving PTSD symptoms. In this case, there is documentation that the patient has neuropathic pain related to the cervical spine and upper extremities. The medication has proved beneficial. Medical necessity for Topiramate has been established. The requested medication is medically necessary.

1 Physical therapy referral: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. According to the records, this patient has had 25+ PT visits and there is no documentation indicating that she had a defined functional improvement in her condition. There is no specific indication for the requested physical therapy referral. Medical necessity for the requested service is not established. The requested services are not medically necessary.