

Case Number:	CM15-0067772		
Date Assigned:	04/15/2015	Date of Injury:	12/19/2007
Decision Date:	05/28/2015	UR Denial Date:	03/18/2015
Priority:	Standard	Application Received:	04/09/2015

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: Iowa

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 49 year old female, who sustained an industrial injury on 12/19/07. The injured worker has complaints of gastric symptoms along with he has numbness and tingling and burning in her hands and feet. The worker also reports R shoulder, neck, and lower back pain. Exam showed tenderness to palpation in the R shoulder with impingement, and lower back with spasm, along with decreased lower extremity sensation. The diagnoses have included cervical radiculopathy; lumbar radiculopathy and shoulder impingement. Treatment to date has included multiple medications and magnetic resonance imaging (MRI). The request was for carisoprodol, gabapentin, and tramadol.

IMR ISSUES, DECISIONS AND RATIONALES

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

Carisoprodol 350 mg, sixty count with two refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Antispasmodics, Muscle relaxants, Carisoprodol Page(s): 60-61,

63-66, 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle Relaxants.

Decision rationale: Carisoprodol (Soma) is a muscle relaxant class medication. According to MTUS guidelines, muscle relaxants are recommended for chronic pain for a short course of therapy for acute exacerbations. Muscle relaxants may be effective in reducing pain and muscle tension, but in most back pain cases they show no benefit beyond NSAIDs. Evidence indicates the greatest effect is seen in the first 4 days of treatment. MTUS also states that pain relief is generally temporary, and continued evaluation should include documentation improvement in function and increased activity. Both MTUS and ODG state that Carisoprodol is not recommended, due to the main effect of generalized sedation and treatment of anxiety and potential for abuse. The medical documentation indicates the patient has been on this medication for an extended period of time, exceeding the short-term recommendation for treatment length. The treating physician has not provided rationale for the extended use of this medication, and does not include sufficient documentation regarding the reported pain over time or specific improvement while on this medication. The documentation indicates that the patient continues to have pain and decreased functional status. The only potential indication is the documentation of muscle spasms, but it is unclear if these are acute in nature or if the medication is helping with these symptoms since they are still occurring despite ongoing therapy. The patient is also on other chronic pain medication, which is not recommended. Carisoprodol is also not recommended by guidelines. Therefore the request for Carisoprodol 350 mg #60 2 refills, is not medically necessary.

AcipHex DR 20 mg, sixty count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: AcipHex is the brand name for rabeprazole, a proton pump inhibitor (PPI). According to MTUS guidelines, this type of medication is recommended in patients at intermediate or high risk for gastrointestinal (GI) events and who have no cardiovascular disease. The guidelines provide criteria for risk stratification for gastrointestinal events. Risk factors include (1) age >65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. Use of the medication is meant to serve as protection from GI issues. Other indications for use of this medication would be for primary GI disorders such as reflux disease. Long-term PPI use has significant side effects including increased risk of hip fracture. The medical documentation does not provide evidence of a primary GI disorder, bleeding, perforation, peptic ulcer, high dose NSAID, ASA use, or other GI risk factors. The treating physician does not provide any additional justification or indication for use of the medication. Therefore, the request for rabeprazole 20 mg #60, is not medically necessary at this time.

Gabapentin 300 mg, ninety count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs, Gabapentin Page(s): 16-22, 49, 113, 18-20. Decision based on Non-MTUS Citation Chronic Pain, Anti-epilepsy drugs (AEDs) for pain, Gabapentin (Neurontin).

Decision rationale: According to MTUS guidelines, Gabapentin is a first-line treatment for neuropathic pain, and should only be continued when there is a clear documented improvement in pain. It is not recommended for other types of chronic pain. A trial period is recommended, and if inadequate control of pain is found, MTUS recommends switching to another first-line drug. Combination therapy is only recommended if there is no change with first-line therapy and evidence shows significant improvement on the medications. ODG also recommends primary treatment for neuropathy, and that if inadequate control is found to switch to another first-line drug. The patient appears to have been on this medication for an extended period of time. The medical documentation states that the medication provides relief and ability to function, but no objective measures of improvement in pain symptoms or functional status on this medication. There is also only subjective evidence of a neuropathic basis for the chronic pain. The documentation indicates the patient continues to have chronic pain and limitations overall. Therefore, the request for Gabapentin 300 mg #90 is not medically necessary at this time.

Tramadol 50 mg, 34 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol Page(s): 74-96, 113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids.

Decision rationale: Tramadol is classified as a central acting synthetic opioid, exhibiting opioid activity. According to MTUS guidelines, tramadol is not recommended as a first-line oral analgesic. ODG states that tramadol is not recommended as a first-line oral analgesic because of its inferior efficacy to a combination of Hydrocodone/ acetaminophen. According to MTUS guidelines, opioids are indicated mainly for osteoarthritis only after first-line conservative options have failed, and should include clear improvement in pain and functional status for continued use. There is limited evidence to support long-term use for back or other musculoskeletal pain. MTUS also states that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur and an improved response to treatment should be observed. MTUS recommends discontinuing therapy if there is no improvement in pain or function. ODG does not recommend the use of opioids for musculoskeletal pain except for short use for severe cases, not to exceed two weeks. The medical documentation indicates the patient has been on this medication for an extended period of time,

exceeding the two-week recommendation for treatment length. The treating physician has not provided rationale for the extended use of this medication, and does not include sufficient documentation regarding the reported pain over time or specific functional improvement while on this medication. Documentation indicates the patient continues to have pain and decreased functional status. Therefore, the request for Tramadol 50 mg #34, is not medically necessary.