

Case Number:	CM15-0069082		
Date Assigned:	04/16/2015	Date of Injury:	01/25/2010
Decision Date:	05/15/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	04/13/2015

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: California

Certification(s)/Specialty: Family Practice

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 1/25/10. She has reported initial complaints of low Back pain after twisting injury working in child care. The diagnoses have included lumbar radiculopathy, displacement of lumbar intervertebral disc without myelopathy, lumbar disc degeneration, chronic pain syndrome, depression and anxiety. Treatment to date has included medications, diagnostics, physical therapy, conservative measures, activity modifications and home exercise program (HEP). The current medications included Celebrex, Cyclobenzaprine, and Docusate sodium, Fluoxetine, Gabapentin, Norco and Omeprazole. Currently, as per the physician progress encounter note dated 3/20/15, the injured worker complains of chronic low back pain that is progressively worsening and described as stabbing and tingling. The pain was rated 10/10 on pain scale at office visit. There was associated left lower extremity (LLE) weakness, numbness and tingling. She also reported back stiffness, problems with sleeping and depression which the injured worker reports that the pain improves with use of medications such as Celebrex with 40 percent relief of pain. She reports that the medications decrease pain from 10/10 down to 5/10. It was noted that she attempted physical therapy times one and was told by the therapist she could not participate and was discharged without any further physical therapy. Physical exam revealed she was not striking left heel, difficulty ambulating with frequent rest periods, facial grimacing was noted, ambulatory behaviors were guarded movements and she had to lie down frequently. The physician noted that the injured worker had persistent low back pain with radicular symptoms which limits her

functionality. The recommendations were exercise as tolerated and continue with medications as prescribed. The physician requested treatments included Celebrex 200mg #30, refills: 2, Docusate Sodium 100mg #30, refill: 2, and Gabapentin 300mg #30, refill: 2 for chronic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Celebrex 200mg #30, refills: 2: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of NSAIDs including Celebrex. The specific MTUS recommendations are as follows:
Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxen being the safest drug). There is no evidence of long-term effectiveness for pain or function.
Back Pain Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP.
Back Pain Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another.
Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. In this case, the records indicate that Celebrex is being used as a long-term treatment strategy for this patient's chronic pain. Long-term use per the above cited guidelines is not recommended. Therefore, for this reason, Celebrex is not medically necessary.

Docusate Sodium 100mg #30, refill: 2: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Pain/Chronic Section: Opioid-Induced Constipation.

Decision rationale: The Official Disability Guidelines comment on the use of medications to address opioid-induced constipation. There recommendations are as follows: If prescribing opioids has been determined to be appropriate, then ODG recommends, under Initiating Therapy, that Prophylactic treatment of constipation should be initiated. Opioid-induced constipation is a common adverse effect of long-term opioid use because the binding of opioids to peripheral opioid receptors in the gastrointestinal (GI) tract results in absorption of electrolytes, such as chloride, with a subsequent reduction in small intestinal fluid. Activation of enteric opioid receptors also results in abnormal GI motility. Constipation occurs commonly in patients receiving opioids and can be severe enough to cause discontinuation of therapy. First-line: When prescribing an opioid, and especially if it will be needed for more than a few days, there should be an open discussion with the patient that this medication may be constipating, and the first steps should be identified to correct this. Simple treatments include increasing physical activity, maintaining appropriate hydration by drinking enough water, and advising the patient to follow a proper diet, rich in fiber. These can reduce the chance and severity of opioid-induced constipation and constipation in general. In addition, some laxatives may help to stimulate gastric motility. Other over-the-counter medications can help loosen otherwise hard stools, add bulk, and increase water content of the stool. In this case, there is insufficient documentation in the records that the patient is experiencing constipation. Further, there is insufficient documentation that the above-cited first-line treatments have been recommended; to including maintaining hydration, following a proper diet and increasing fiber. Under these conditions, Docusate is not a medically necessary treatment.

Gabapentin 300mg #30, refill: 2: 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 Page(s): 16-18.

Decision rationale: The MTUS/Chronic Pain Medical Treatment guidelines comment on the use of anti-epilepsy drugs (AEDs), including gabapentin. AEDs are recommended for neuropathic pain (pain due to nerve damage). 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. Outcome: 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. In this case there is insufficient documentation that the patient meets the criteria for the use of an AED; specifically, whether the patient has a radiculopathy. The documentation of radiculitis in the assessment is not supported by content in the history, physical examination or radiographs/electrodiagnostic studies available for review. Further, there is insufficient evidence that the use of gabapentin has led to documented improved outcomes, as indicated above in the MTUS guidelines. For these reasons, gabapentin is not a medically necessary treatment.