

Case Number:	CM15-0074024		
Date Assigned:	04/24/2015	Date of Injury:	04/03/2001
Decision Date:	05/21/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	04/17/2015

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, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 female with an industrial injury dated April 3, 2001. The injured worker diagnoses include status post L5-S1 fusion in 1985 and L3-L5 laminectomy and fusion in 9/2012, lumbar spine degenerative disc disease with chronic low back pain and right radicular pain and chronic pain syndrome with long-term use of narcotics and history of narcotic overdose. She has been treated with diagnostic studies, prescribed medications, pain management, physical therapy, home exercise therapy, epidural steroid injection, walker and periodic follow up visits. According to the progress note dated 3/04/2015, the injured worker reported chronic low back pain. The injured worker also reported constant lower back radiating to right lateral thigh and leg and pain at bilateral knees/legs. Objective findings revealed antalgic gait without foot drop, decrease lumbar and right knee range of motion, positive straight leg raises on the right, decrease sensation at the right lateral thigh and leg, and tenderness at lower lumbar paraspinal muscles without muscle spasm. The treating physician prescribed Methadone 5mg #120 with 2 refills, Neurontin 300mg #150 with 2 refills and Trazodone 100mg #90 with 2 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Methadone 5mg #120 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Methodone, Criteria for Use of Opioids, Weaning of Medications Page(s): 93, 78-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Methadone Page(s): 74-96.

Decision rationale: MTUS does not discourage use of opioids past 2 weeks, but does state that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include the following: 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. The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, or increased level of function. Medical documentation provided indicate this patient has been taking this medication in excess of the 2 week recommendations. As such, the request for Methadone 5mg #120 with 2 refills is not medically necessary.

Neurontin 300mg #150 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs, Gabapentin (Neurontin) Page(s): 18-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Anti-epilepsy drugs (AEDs) for pain, Gabapentin (Neurontin;^{1/2}).

Decision rationale: The MTUS considers Gabapentin as a first-line treatment for neuropathic pain and effective for the treatment of spinal cord injury, lumbar spinal stenosis, and post op pain. MTUS also recommends a trial of Gabapentin for complex regional pain syndrome. ODG states "Recommended Trial Period: One recommendation for an adequate trial with Gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. (Dworkin, 2003) The patient should be asked at each visit as to whether there has been a change in pain or function. Current consensus based treatment algorithms for diabetic neuropathy suggests that if inadequate control of pain is found, a switch to another first-line drug is recommended." Additionally, ODG states that 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 treating physician has failed provided documentation of objective functional improvement with the use of this medication. As such, the request for Neurontin 300mg #150 with 2 refills is not medically necessary.

Trazodone 100mg #90 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Insomnia treatment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Trazodone.

Decision rationale: Regarding Trazodone, the above cited guidelines say: Recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. See also Insomnia treatment, where it says there is limited evidence to support its use for insomnia, but it may be an option in patients with coexisting depression. The current recommendation is to utilize a combined pharmacologic and psychological and behavior treatment when primary insomnia is diagnosed. Also worth noting, there has been no dose-finding study performed to assess the dose of trazodone for insomnia in non-depressed patients. Other pharmacologic therapies should be recommended for primary insomnia before considering trazodone, especially if the insomnia is not accompanied by comorbid depression or recurrent treatment failure. There is no clear-cut evidence to recommend trazodone first line to treat primary insomnia. The medical documentation provided does not indicate objective functional improvement with the use of this medication. The treating physician states that this patient has had no improvement with sleep with this medication. As such, the request for Trazodone 100mg #90 with 2 refills is not medically necessary.