

<b>Case Number:</b>	CM13-0026265		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	02/24/2000
<b>Decision Date:</b>	08/05/2014	<b>UR Denial Date:</b>	08/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2013

### 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. The expert reviewer is Board Certified in Neurology and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 (IW) is a 53-year old female who cites severe back, cervical spine and neck pain after falling two feet from a ladder on 2/24/2000. Reports indicate that the IW was treated with medications for approximately 4 years. In 2004 she underwent a 2-level ACDF (C5-6, C6-7) which provided some improvement in symptomology after a prolonged recovery (two years). An MRI obtained 7/3/13 indicates status post-fusion with central canal stenosis at C4-5 and a broad-based posterior disc/osteophyte complex possibly contacting the ventral cervical cord. A lumbar MRI in 2008 shows moderate bilateral L4-5 and L5-S1 facet joint arthropathy and moderate broad-size bulge at L5-S1 causing mild to moderate left lateral recess narrowing without central spinal stenosis. MRI of lumbar spine in 2004 reveals degenerative disk disease at L1-L2, T12-L1 and L5-S1. Currently the patient suffers neck pain radiating to both upper extremities and persistent lower back pain. The primary diagnosis is chronic pain syndrome, with additional diagnoses of lumbosacral spondylosis w/o myelopathy, cervical spondylosis w/o myelopathy, rotator cuff syndrome, and postlaminectomy syndrome (cervical region), depression, insomnia. Since under the care of a pain management physician (earliest progress report provided for this review dates 2/27/13), the IW has been using Kadian (80 mg bid), Percocet (10/325 mg as needed, max4/d) and Trazodone (100 mg x3 at bedtime). No data has been provided as to when this medication treatment was initiated nor the manner in which doses were escalated to the current levels, but it is apparent that the protocol has been in effect since at least 2/2003. The physician notes that this course has allowed the patient to stay active. Treatment plans also indicate use of Baclofen (20 mg TID), and Zomig (5 mg PRN). Past interventions have included epidural steroid injections (e.g., left shoulder, subacromial and intra-articular), and lumbar-specific radiofrequency procedures and blocks which provided partial pain relief. The patient reports that TENS, Chiropractic and Physical therapies did not provide much

improvement. Records also indicate that she has tried Oxycontin, Methadone, Vicodin, Celebrex, Fentanyl patches, Lyrica, Wellbutrin and Zolofit in the past with failed use of NSAIDs. The treating physician submitted a request to refill Kadian, Percocet, and Trazodone at the levels indicated above on 8/23/13. This request was denied on 8/30/13. Upon review of the documentation provided for this review, the previous denial is over-turned and the request to refill these three medications is approved.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**KADIAN 80MG #60:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Goodman and Gilman's Pharmacological Basis of Therapeutics and ODG Workers Compensations Drug Formulary.

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

**Decision rationale:** With regard to the request for Kadian and Percocet: While the Chronic Pain Medical Treatment Guidelines (Opioids, p. 86) recommend that the cumulative calculation of Morphine Equivalent Dose (MED) should not exceed 120 mg oral morphine equivalents, there are other considerations which may be appropriate: Actual maximum safe dose will be patient-specific and dependent on current and previous opioid exposure, as well as on whether the patient is using such medications chronically -- with the caveat that dose-limiting toxicity attributable to acetaminophen, aspirin, or ibuprofen used in combination opioid products prescribed necessarily determine the maximum dose of that product. In this case, the requested prescription of Kadian (80 mg BID) and Percocet/acetaminophen (10/325 mg PRN to max four times per day) is greater than the recommended cumulative MED at 220 mg, but the dosing does not exceed the 4 g acetaminophen amount for known toxicity. Also according to the Guidelines, on occasion (though rare), the daily dose of opioid may be increased above the recommended MED under the care of a pain management provider (p. 86). Further, current studies show that some patients receive up to 180 MEDs (the upper limit of normal) prior to referral to a pain specialist to determine if continuation, escalation, or weaning of opioid use is necessary (p.81). It appears that this patient has been under the care and supervision of a pain management physician within a specialty treatment center, who provides documentation of appropriate frequency of follow-up appointments, appropriately limits refills between appointments, and attests to patient compliance with a signed narcotics-treatment agreement. The physician documents that the patient is being counseled as to the effects of sedating medications and narcotics. It is assumed that the pain specialist shall responsibly monitor this treatment course for indications of opioid tolerance/sensitization, hyperalgesia, and dependency or addiction. It is apparent from the progress reports dated prior to the request of 8/23/13 that the physician is attending to the four domains specific to on-going management of opioid treatment (Criteria for Use of Opioids On-going Management p. 27, The Four A's: Analgesia, Activities of daily living, Adverse side-effects, and Aberrant drug-taking behavior). Specifically, assessment of pain symptoms using scales to document greatest pain, least pain, and typical pain during treatment is

periodically recorded; the treatment reportedly allows the patient to remain active physically and psychosocially; the adverse side-effects likely to limit protracted use or effects known to contraindicate use of these particular medications are assessed regularly, with no indication of adverse effects as yet to their prohibition of continued use; and reports of aberrant/nonadherent drug-related behaviors (e.g., doctor shopping, self-administered dose escalations, pre-mature refill requests, non-compliance with signed treatment agreement, etc.) are absent. The Guidelines indicate that monitoring such outcomes over time should inform the therapeutic decisions regarding the on-going use of opioid medications. Therefore the request is medically necessary.

**PERCOCET 10/325MG #120:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Goodman and Gilmans Pharmacological Basis of Therapeutics and ODG Workers Compensations Drug Formulary.

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

**Decision rationale:** With regard to the request for Kadian and Percocet: While the Chronic Pain Medical Treatment Guidelines (Opioids, p. 86) recommend that the cumulative calculation of Morphine Equivalent Dose (MED) should not exceed 120 mg oral morphine equivalents, there are other considerations which may be appropriate: Actual maximum safe dose will be patient-specific and dependent on current and previous opioid exposure, as well as on whether the patient is using such medications chronically -- with the caveat that dose-limiting toxicity attributable to acetaminophen, aspirin, or ibuprofen used in combination opioid products prescribed necessarily determine the maximum dose of that product. In this case, the requested prescription of Kadian (80 mg BID) and Percocet/acetaminophen (10/325 mg PRN to max four times per day) is greater than the recommended cumulative MED at 220 mg, but the dosing does not exceed the 4 g acetaminophen amount for known toxicity. Also according to the Guidelines, on occasion (though rare), the daily dose of opioid may be increased above the recommended MED under the care of a pain management provider (p. 86). Further, current studies show that some patients receive up to 180 MEDs (the upper limit of normal) prior to referral to a pain specialist to determine if continuation, escalation, or weaning of opioid use is necessary (p.81). It appears that this patient has been under the care and supervision of a pain management physician within a specialty treatment center, who provides documentation of appropriate frequency of follow-up appointments, appropriately limits refills between appointments, and attests to patient compliance with a signed narcotics-treatment agreement. The physician documents that the patient is being counseled as to the effects of sedating medications and narcotics. It is assumed that the pain specialist shall responsibly monitor this treatment course for indications of opioid tolerance/sensitization, hyperalgesia, and dependency or addiction. It is apparent from the progress reports dated prior to the request of 8/23/13 that the physician is attending to the four domains specific to on-going management of opioid treatment (Criteria for Use of Opioids On-going Management p. 27, The Four A's: Analgesia, Activities of daily living, Adverse side-effects, and Aberrant drug-taking behavior). Specifically, assessment of pain symptoms using numeric-scales to document greatest pain, least pain, and typical pain during treatment is periodically recorded; the treatment reportedly allows the patient to remain active

physically and psychosocially; the adverse side-effects likely to limit protracted use or effects known to contraindicate use of these particular medications are assessed regularly, with no indication of adverse effects as yet to their prohibition of use; and reports of aberrant/nonadherent drug-related behaviors (e.g., doctor shopping, self-administered dose escalations, pre-mature re-fill requests, non-compliance with signed treatment agreement, etc.) are absent. The Guidelines indicate that monitoring such outcomes over time should inform the therapeutic decisions regarding the on-going use of opioid medications. Therefore the request is medically necessary.

**TRAZODONE 100MG #90:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Goodman and Gilman's Pharmacological Basis of Therapeutics and ODG Workers Compensations Drug Formulary.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants; Page(s): 14-16.

**Decision rationale:** With regard to the Trazodone request: Tricyclics are recommended as a first-line therapy for neuropathic pain, especially in cases where depression and insomnia are also treatment concerns. While toxicity thresholds are relatively low with this class of drugs and require cautious monitoring for adverse CNS and cardiovascular effects, Guidelines (Antidepressants, pp. 14-16) indicate the dose should be titrated to efficacy and to tolerance on an individual basis. Records provided show that the IW has been using Trazodone with effect and without indication of poor tolerance. Since the interactive effects of tricyclics with other classes of medications have not been well-researched, it is the responsibility of the treating pain specialty physician to have a thorough understanding of the etiology/pathology of the pain and to identify comorbidities that might predict an adverse outcome. Physicians should tailor medications and dosages to the individual taking into consideration patient-specific variables such as comorbidities, other medications, and allergies. The physician should be knowledgeable regarding the prescribing information and adjust the dose to the individual patient. Therefore the request is medically necessary.