

<b>Case Number:</b>	CM13-0028043		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	09/11/2002
<b>Decision Date:</b>	01/23/2014	<b>UR Denial Date:</b>	10/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/17/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine 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 physician 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.

### 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 43-year-old male with a date of injury of September 11, 2002. The injured worker carries a diagnosis of failed back surgery syndrome, myofascial pain, long-term opiate use, and depression secondary to chronic pain. The issues that are disputed include the prescription for MS Contin, gabapentin, and urine drug testing. Specifically, a utilization review determination on October 9, 2013 had modified the request for the MS Contin and the gabapentin, and denied the urine drug test. The clinical rationale for the modification of the MS Contin is that there is limited subjective or objective evidence of a reduction in pain levels and increasing daily function. The reviewer cited that this opiate had been previously reviewed and recommended for weaning. The rationale for the denial of the gabapentin is that "evidence-based guidelines indicate that antiepileptic drugs are only a first-line defense for neuropathic pain if symptoms are reduced by 30%." The reviewer concluded that the patient was beyond the trial phase of the medication and recommended a taper of this medication. The rationale for the denial of the urine drug screen is that urine drug screens are "to be random for patients to assess for the use or the presence of illegal drugs and for patients with issues of abuse, addiction, or poor pain control." The reviewer further asserted that guidelines recommend urine screening test that are quantitative and not qualitative the reviewer noted that since there was a urine drug screen performed last month, the interval was too short as urine drug screen should be performed twice yearly.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) prescription of MS Contin 10mg, #60: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section Page(s): 76-80.

**Decision rationale:** The California Medical Treatment and Utilization Schedule specifies on pages 76-80 of the Chronic Pain Medical Treatment Medical Guidelines the following Criteria for Use of Opioids: Therapeutic Trial of Opioids

- 1) Establish a Treatment Plan. The use of opioids should be part of a treatment plan that is tailored to the patient. Questions to ask prior to starting therapy:
  - (a) Are there reasonable alternatives to treatment, and have these been tried?
  - (b) Is the patient likely to improve? Examples: Was there improvement on opioid treatment in the acute and subacute phases? Were there trials of other treatment, including non-opioid medications?
  - (c) Is there likelihood of abuse or an adverse outcome? See Substance abuse (tolerance, dependence, addiction).
  - (d) Ask about Red Flags indicating that opioids may not be helpful in the chronic phase:
    - (1) Little or no relief with opioid therapy in the acute and subacute phases.
    - (2) The patient has had a psychological evaluation and has been given a diagnosis of somatoform disorder.
    - (3) The patient has been given a diagnosis in one of the particular diagnostic categories that have not been shown to have good success with opioid therapy: conversion disorder; somatization disorder; pain disorder associated with psychological factors (such as anxiety or depression).
  - (e) When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision.
- 2) Steps to Take Before a Therapeutic Trial of Opioids:
  - (a) Attempt to determine if the pain is nociceptive or neuropathic. Also attempt to determine if there are underlying contributing psychological issues. Neuropathic pain may require higher doses of opioids, and opioids are not generally recommended as a first-line therapy for some neuropathic pain.
  - (b) A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics.
  - (c) Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals.
  - (d) Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale. See Function Measures.
  - (e) Pain related assessment should include history of pain treatment and effect of pain and function.
  - (f) Assess the likelihood that the patient could be weaned from opioids if there is no improvement in pain and function.
  - (g) The patient should have at least one physical and psychosocial assessment by the treating doctor (and a possible second opinion by a specialist) to assess whether a trial of opioids should occur. When subjective complaints do not correlate

**One (1) prescription of Gabapentin 600 mg, #90, with three (3) refills:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19.

**Decision rationale:** The Chronic Pain Medical Treatment Medical Guidelines pages 18-19 state the following: "Gabapentin (Neurontin®<sup>®</sup>, Gabarone<sup>®</sup>, generic available) 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. (Backonja, 2002) (ICSI, 2007) (Knotkova, 2007) (Eisenberg, 2007) (Attal, 2006) This RCT concluded that gabapentin monotherapy appears to be efficacious for the treatment of pain and sleep interference associated with diabetic peripheral neuropathy and exhibits positive effects on mood and quality of life. (Backonja, 1998) It has been given FDA approval for treatment of post-herpetic neuralgia. The number needed to treat (NNT) for overall neuropathic pain is 4. It has a more favorable side-effect profile than Carbamazepine, with a number needed to harm of 2.5. (Wiffen<sup>2</sup>-Cochrane, 2005) (Zaremba, 2006) Gabapentin in combination with morphine has been studied for treatment of diabetic neuropathy and postherpetic neuralgia. When used in combination the maximum tolerated dosage of both drugs was lower than when each was used as a single agent and better analgesia occurred at lower doses of each. (Gilron-NEJM, 2005) Recommendations involving combination therapy require further study. Mechanism of action: This medication appears to be effective in reducing abnormal hypersensitivity (allodynia and hyperalgesia), to have anti-anxiety effects, and may be beneficial as a sleep aid. (Arnold, 2007) Specific pain states: There is limited evidence to show that this medication is effective for postoperative pain, where there is fairly good evidence that the use of gabapentin and gabapentin-like compounds results in decreased opioid consumption. This beneficial effect, which may be related to an anti-anxiety effect, is accompanied by increased sedation and dizziness. (Peng, 2007) (Buvanendran, 2007) (Menigaux, 2005) (Pandey, 2005) Spinal cord injury: Recommended as a trial for chronic neuropathic pain that is associated with this condition. (Levendoglu, 2004) CRPS: Recommended as a trial. (Serpell, 2002) Fibromyalgia: Recommended as a trial. (Arnold, 2007) Lumbar spinal stenosis: Recommended as a trial, with statistically significant improvement found in walking distance, pain with movement, and sensory deficit found in a pilot study. (Yaksi, 2007) Side-Effect Profile: Gabapentin has a favorable side-effect profile, few clinically significant drug-drug interactions and is generally well tolerated; however, common side effects include dizziness, somnolence, confusion, ataxia, peripheral edema, and dry mouth. (Eisenberg, 2007) (Attal, 2006) Weight gain is also an adverse effect. Dosing Information: Postherpetic neuralgia - Starting regimen of 300 mg once daily on Day 1, then increase to 300 mg twice daily on Day 2; then increase to 300 mg three times daily on Day 3. Dosage may be increased as needed up to a total daily dosage of 1800

**One (1) urine drug screen:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43, 76-80.

**Decision rationale:** The Chronic Pain Medical Treatment Medical Guidelines state the following regarding urine drug testing on page 43: "Drug testing: Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. For more information, see Opioids, criteria for use: (2) Steps to Take Before a Therapeutic Trial of Opioids & (4) On-Going Management; Opioids, differentiation: dependence & addiction; Opioids, screening for risk of addiction (tests); & Opioids, steps to avoid misuse/addiction." The sections cited above are excerpted below from pages 76-80 of the Chronic Pain Medical Treatment Medical Guidelines: "2) Steps to Take Before a Therapeutic Trial of Opioids: (a) Attempt to determine if the pain is nociceptive or neuropathic. Also attempt to determine if there are underlying contributing psychological issues. Neuropathic pain may require higher doses of opioids, and opioids are not generally recommended as a first-line therapy for some neuropathic pain. (b) A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. (c) Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. (d) Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale. See Function Measures. (e) Pain related assessment should include history of pain treatment and effect of pain and function. (f) Assess the likelihood that the patient could be weaned from opioids if there is no improvement in pain and function. (g) The patient should have at least one physical and psychosocial assessment by the treating doctor (and a possible second opinion by a specialist) to assess whether a trial of opioids should occur. When subjective complaints do not correlate with imaging studies and/or physical findings and/or when psychosocial issue concerns exist, a second opinion with a pain specialist and a psychological assessment should be obtained. (h) The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian. (i) A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. Patient, guardian, and caregiver attitudes about medicines may influence the patient's use of medications for relief from pain. See Guidelines for Pain Treatment Agreement. This should include the consequences of non-adherence. (j) Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs. 4) On-Going Management. Actions Should Include: (a) Prescriptions from a single pra