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| Case Number: | CM13-0040150 | | |
| Date Assigned: | 06/09/2014 | Date of Injury: | 02/17/2012 |
| Decision Date: | 08/08/2014 | UR Denial Date: | 10/23/2013 |
| Priority: | Standard | Application Received: | 10/29/2013 |

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, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in New Jersey. 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 patient is a 42-year-old man who sustained a work-related injury on February 17, 2012. Subsequently, he developed left foot pain. According to a progress report dated on May 9, 2014, the patient has severe pain on the dorsum of the right foot, which is now extending up the lateral aspect of the left leg. There is also pronounced swelling in the left foot. His pain is now constant in duration and became progressively worse. He describes the character of the pain as aching, sharp, and cold. His pain is worse with standing, walking, bending, and lifting. He has difficulty sleeping at night secondary to pain. The patient underwent a trial with a spinal cord stimulator. With the trial, his pain level went from a 9/10 to a 4/10. His activity level also increased. He was implanted with the device on March, 20, 2014. Prior to the trial, he underwent an MRI of the thoracic spine. The study revealed no spinal stenosis. An MRI of the left foot dated on August 17, 2012 showed: Redemonstration of comminuted calcaneal fracture with the fracture line extending into the subtalar and calcaneocuboid joints. There is mild displacement; Fracture involving the third cuneiform in the bases of the second, third, and fourth metatarsals. There is residual intense bone edema of these structures. There is also edema of the navicular and cuboid bones; the intrinsic ligaments of the ankle and also the spring ligament appear to be intact; The long tendons around the ankle exhibit normal signal. There is no evidence of tenosynovitis; There are some changes involving the plantar tip of the calcaneus and the adjacent proximal fibers of the plantar fascii that suggest plantar fasciitis; CT of the left ankle without contrast dated December 27, 2012 showed; healed fracture of the proximal fourth metatarsal with incomplete bony union; Spotty osteoporosis, which may represent diffuse atrophy; and Type 1 vertical fracture of the talus, which demonstrates incomplete bony union. An examination of the extremities revealed a pronounced allodynia over the dorsum and lateral aspect of the left foot. There is an abnormality with the toenail of the left great toe. Range of motion of the left foot,

with respect to plantar flexion, is essentially normal. Range of motion of the left foot, with respect to dorsiflexion, is approximately 80% of that of the right foot. Inversion and eversion are comparable to that of the right foot. There is a sensory deficit to light touch along the lateral left leg. Straight leg raising test and FABER test were negative bilaterally. The patient was diagnosed with foot fracture and peripheral neuropathy. The patient's treatment included: physical therapy and medications (Keflex, Norco, Lidoderm patches, Lyrica). The provider requested authorization for Dilaudid and Neurontin.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION OF DILAUDID 2MG #60 WITH 2 REFILLS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) < Criteria for use of opioids, page(s) 179.

Decision rationale: According to the MTUS guidelines, Dilaudid is a short acting opioids is seen an effective medication to control pain. Hydromorphone (Dilaudid; generic available): Side Effects such as respiratory depression and apnea are of major concern. Patients may experience some circulatory depression, respiratory arrest, shock and cardiac arrest. The more common side effects are dizziness, sedation, nausea, vomiting, sweating, dry mouth and itching. According to the MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: 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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring are: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. Based on the records, the patient has used opiates since at least March 2012 with no significant improvement. The provider stopped the Norco due to ineffectiveness (May 2013). There is no significant improvement of function and pain with continuous use of Dilaudid. In addition, there is no urine drug screen documenting the patient compliance with prescribed medications. Therefore, the prescription of Dilaudid 2mg is not medically necessary.

1 PRESCRIPTION OF NEURONTIN 100MG #60 WITH 2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIEPILEPSY DRUGS (AEDS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49.

Decision rationale: According to the MTUS, Neurontin has been shown to be effective for the treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered to be first line treatment for neuropathic pain. Although the patient developed neuropathic left foot pain, continuous use of Neurontin cannot be certified without documentation of efficacy. Therefore the request for Neurontin 100mg #60 with 2 refills cannot be certified without proof of drug efficacy. Therefore, one (1) prescription of Neurontin 100mg #60 is not medically necessary.