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| Case Number: | CM14-0128699 | | |
| Date Assigned: | 08/18/2014 | Date of Injury: | 03/17/2002 |
| Decision Date: | 10/01/2014 | UR Denial Date: | 08/08/2014 |
| Priority: | Standard | Application Received: | 08/13/2014 |

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 Physical Medicine and Rehabilitation 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 patient is a 64 year old female who sustained an industrial injury on 3/17/2002, now 12.5 years s/p DOI. She is status post 2002 lumbar fusion. She continues chronic pain management for diagnosed lumbar spine post-laminectomy syndrome. A prior peer review dated 8/8/2014 by [REDACTED] certified the requests of MS Contin 60mg #84, MS Contin 30mg #28, and Elavil 25mg #28. The request for Endocet 10/325 mg #140 was modified to allow #53 and the request for Neurontin 300mg #140 was non-certified. She continues weaning from MS Contin and Endocet. The patient recently returned for routine pain management follow up on 8/20/2014 for medication refill. She has low back pain which is more intense in the evening. Pain is sharp and intermittent. Pain is rated 7/10. She is not working. Physical examination documents tenderness in the right and left paravertebral regions at L2-3 though L5-S1 levels, restricted lumbar ROM, positive SLR on the left, and 5/5 motor strength of the lower extremities. Assessment is lumbar radiculopathy, post laminectomy syndrome. Treatment plan is continued medications. The patient is dispensed Elavil 25mg #28, Endocet 10/325mg #140, MS Contin 60mg ER #84, and Neurontin 300mg #140. Follow up in 4 weeks. Authorization for medications is requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 300mg #140: Overturned

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 Antiepilepsy drugs Page(s): 16.

Decision rationale: The CA MTUS state Antiepilepsy drugs (AEDs) medications are recommended for neuropathic pain (pain due to nerve damage). Gabapentin (Neurontin, Gabarone, 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. The patient is diagnosed with lumbar radiculopathy and post laminectomy syndrome. These are considered diagnoses for neuropathy, so Neurontin is appropriate, and is medically necessary for the treatment of this patient's condition. Therefore, I am reversing the prior UR decision.

Endocet 10/325mg #140: 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 Opioids Page(s): 74-85.

Decision rationale: CA MTUS - Short-acting opioids: also known as "normal-release" or "immediate-release" opioids are seen as an effective method in controlling chronic pain. They are often used for intermittent or breakthrough pain. These agents are often combined with other analgesics such as acetaminophen and aspirin. These adjunct agents may limit the upper range of dosing of short acting agents due to their adverse effects. The duration of action is generally 3-4 hours. Short acting opioids include Morphine (Roxanol), Oxycodone (OxyIR, Oxyfast), Endocodone, Oxycodone with acetaminophen, (Roxilox, Roxicet, Percocet, Tylox, Endocet), Hydrocodone with acetaminophen, (Vicodin, Lorcet, Lortab, Zydone, Hydrocet, Norco), Hydromorphone (Dilaudid, Hydrostat). According to the guidelines, opioids for chronic back pain appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. In patients taking opioids for back pain, the prevalence of lifetime substance use disorders has ranged from 36% to 56%. Limited information indicated that up to one-fourth of patients who receive opioids exhibit aberrant medication-taking behavior. The guidelines indicate opioids should be continued if the patient has returned to work and if the patient has improved functioning and pain. The patient reports having 7/10 level pain low back pain that is intermittent. She has not returned to work and functional improvement and reduction in pain level with medication is not evident. Additionally, the guidelines recommend that opioid dosing not exceed 120 mg oral Morphine equivalents per day, and for patients taking more than one opioid, the Morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. The prescribed opioids MED equals 230 mg, which grossly exceeds the maximum recommended (Morphine equivalent dosage) MED. Given all of these factors, continuation of opioids is not recommended as medically necessary. As per the guidelines, gradual weaning is recommended for long term opioid users due to probable risk of

withdrawal symptoms, with recommendation that weaning of short-acting opioids should take place before long-acting opioids.