

<b>Case Number:</b>	CM14-0161572		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	12/28/2010
<b>Decision Date:</b>	11/26/2014	<b>UR Denial Date:</b>	09/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2014

### 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 Family Practice 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:

This 67-year old chief engineer reported injuries to his left knee, right shoulder and wrist after tripping and falling on 12/28/10. His initial diagnoses in the emergency room included a fracture of the right humerus. Apparently injuries of the neck and low back have been added subsequently. Past medical history is significant for a birth defect which resulted in limited use of right arm and leg since childhood. Treatment has included medications, physical therapy, chiropractic manipulation, a right shoulder reverse arthroplasty in 2013, a right total knee replacement, lumbar epidural steroid injection, and lumbar medial branch block. The primary provider appears to be treating the patient's neck and back injuries. The records also contain notes from a secondary provider which address the patient's right shoulder and wrist injuries. There are four progress notes in the records from the primary provider, with dates ranging from 5/14/14 to 9/2/14. Diagnoses recorded for these visits include severe right neural foraminal narrowing at L3-4, multilevel disc herniation of the cervical spine, cervical radiculopathy and lumbar radiculopathy. Only two of the notes mention the patient's functional status, which appears to be very limited, with no improvement noted. The patient's pain levels in neck, back and right shoulder did not improve over the nearly 4-month period involved. The medications prescribed or dispensed at all of the visits included gabapentin, Tramadol ER #30 and Percocet 10/25 #180, with the rationale that the medications would allow the patient to avoid withdrawal symptoms until he is able to see a pain specialist. Apparently the recommended pain specialist's office has refused to let the patient make an appointment with them, so refills of the listed medications have continued. The most recent report from the primary provider is dated 9/2/14. The patient's complaints include moderate neck pain, moderate-severe back pain, and severe right shoulder pain. No functional status is noted except that the patient has to walk with his arm up as if it is in a sling. The provider notes that the patient held his right upper extremity in

flexion contracture throughout the exam. Exam findings include limited back and neck range of motion, severely limited right shoulder range of motion, extreme weakness (0/5) of the right foot and ankle, and positive straight leg raise on the right. Plan includes a request for a right L2-3 lumbar facet rhizotomy, continued recommendation of consultation with a pain specialist, and requests for Tramadol ER 150mg #30 and Percocet 10/325 mg # 180, with the rationale that it will avoid withdrawal and a trip to the ER while the patient finds a pain management specialist. The patient has not worked since 7/9/12.

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

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

#### **Percocet 10/325mg #180: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (Opioids) On Going Management Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Criteria for use of Opioids, Opioids for Neuropathic Pain, Opioid.

**Decision rationale:** Percocet is brand-name Acetaminophen with Oxycodone, which is an opioid medication and therefore falls under guidelines for medications in general and for opioids specifically. According to the first guideline cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The remaining guidelines state that opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine if the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. There are very limited numbers of studies that involve opioid treatment for chronic lumbar root pain. A recent study found that chronic radicular lumbar pain did not respond to opioids in doses that have been effective for painful diabetic neuropathy and postherpetic neuralgia. Patients taking opioids sometimes develop abnormal pain, a change in pain pattern, or persistence in pain at higher levels than expected, which are actually a result of taking opioids. This is called opioid hyperalgesia. Opioid hyperalgesia should be screened for, as it actually may require weaning off opioids rather than increasing doses. The clinical findings in this case do not demonstrate that any of the above criteria have been met. There is no documentation that Percocet was introduced individually, with ongoing careful assessment of function. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. Many of the documented symptoms as well as diagnoses (cervical and lumbar radiculopathy) and treatments (Gabapentin and epidural injections) make it appear that the patient's pain is neuropathic. Neuropathic pain does not necessarily respond well to opioids. No assessment was made of whether or not opioid use was likely to be helpful in this patient, or of his potential for abuse. No specific functional goals were

set or followed. No evaluation for opioid hyperalgesia has been made. Most importantly, Percocet was not discontinued when it became clear that it has not produced any functional improvement. There is no documentation of any improvement in this patient's level of function from 5/14/14 to 9/2/14. He remains off work, unable to move his right shoulder and barely able to walk. This is more than adequate evidence that this patient is not responding appropriately to this medication, and that it should be discontinued. Based on the evidence-based guidelines cited above, and the clinical documentation provided for my review, Percocet 10/325 #180 is not medically necessary for this patient.

**Tramadol ER 150mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (Opioids) On Going Management Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain; Criteria for use of Opioids; Opioids for Neuropathic Pain; Opioid.

**Decision rationale:** Tramadol is and opioid medication and therefore falls under guidelines for medications in general and for opioids specifically. According to the first guideline cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The remaining guidelines state that opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine in the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. There are very limited numbers of studies that involve opioid treatment for chronic lumbar root pain. A recent study found that chronic radicular lumbar pain did not respond to opioids in doses that have been effective for painful diabetic neuropathy and postherpetic neuralgia. Patients taking opioids sometimes develop abnormal pain, a change in pain pattern, or persistence in pain at higher levels than expected, which are actually a result of taking opioids. This is called opioid hyperalgesia. Opioid hyperalgesia should be screened for, as it actually may require weaning off opioids rather than increasing doses. The clinical findings in this case do not demonstrate that any of the above criteria have been met. There is no documentation that Tramadol was introduced individually, with ongoing careful assessment of function. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. Many of the documented symptoms as well as diagnoses (cervical and lumbar radiculopathy) and treatments (Gabapentin and epidural injections) make it appear that the patient's pain is neuropathic. Neuropathic pain does not necessarily respond well to opioids. No assessment was made of whether or not opioid use was likely to be helpful in this patient, or of his potential for abuse. No specific functional goals were set or followed. No evaluation for opioid hyperalgesia has been made. . There is no documentation of any improvement in this patient's level of function from 5/14/14 to 9/2/14. He remains off work, unable to move his right shoulder and barely able

to walk. This is more than adequate evidence that this patient is not responding appropriately to this medication, and that it should be discontinued. Based on the evidence-based guidelines cited above, and the clinical documentation provided for my review, Tramadol ER #30 is not medically necessary for this patient.