

Case Number:	CM14-0169023		
Date Assigned:	10/17/2014	Date of Injury:	10/15/2012
Decision Date:	11/20/2014	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	10/14/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 51-year-old male with a 10/15/12 date of injury. At the time (9/8/14) of request for authorization for Neurontin 600mg, Duragesic patch 75mcg, and Relafen 750mg, there is documentation of subjective (neck pain, headaches, and shooting pain down the upper extremities) and objective (muscle spasm and tenderness to palpitation over the lower cervical and right supraclavicular region, positive right sided Spurling's test, positive right side Tinel's test, and restricted range of motion of the cervical spine) findings, current diagnoses (cervical disc degeneration, bilateral ulnar neuropathies, post concussion syndrome, and chronic myofascial pain syndrome), and treatment to date (TENS unit, Epidural Steroid injection and medications (including ongoing treatment with Neurontin, Duragesic patch and Relafen since at least 4/23/14)). Medical reports identify previous Ultram use. Regarding Neurontin 600mg and Relafen 750mg, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Neurontin and Relafen use to date. Regarding Duragesic patch 75mcg, there is no documentation of Duragesic patch not used as first line therapy; persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; the patient has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Duragesic 5 mcg/h; no contraindications exist; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of Duragesic patch.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 600mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs, Gabapentin.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (gabapentin). MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of cervical disc degeneration, bilateral ulnar neuropathies, post concussion syndrome, and chronic myofascial pain syndrome. In addition, there is documentation of neuropathic pain. However, given documentation of ongoing treatment with Neurontin, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Neurontin use to date. Therefore, based on guidelines and a review of the evidence, the request for Neurontin 600mg is not medically necessary.

Duragesic patch 75mcg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system) Page(s): 44. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Duragesic and Fentanyl Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, and FDA

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means, as criteria necessary to support the medical necessity of Duragesic. MTUS Chronic Pain Medical Treatment Guidelines identifies that Duragesic is not recommended as first-line therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation that Duragesic is not for use in routine musculoskeletal pain. FDA identifies documentation of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient is already receiving opioid therapy,

has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Duragesic 25 mcg/h; and no contraindications exist, as criteria necessary to support the medical necessity of Duragesic patch. Within the medical information available for review, there is documentation of diagnoses of cervical disc degeneration, bilateral ulnar neuropathies, post concussion syndrome, and chronic myofascial pain syndrome. However, there is no documentation of Duragesic patch not used as a first-line therapy. In addition, despite documentation of pain, there is no documentation of persistent, moderate to severe chronic pain. Furthermore, there is no documentation of pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means. Moreover, given documentation of previous Ultram use, there is no documentation that the patient has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Duragesic 25 mcg/h; and no contraindications exist. Lastly, given documentation of ongoing treatment with Duragesic patch, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Duragesic patch use to date. Therefore, based on guidelines and a review of the evidence, the request for Duragesic patch 75mcg is not medically necessary.

Relafen 750mg: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations,

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of cervical disc degeneration, bilateral ulnar neuropathies, post concussion syndrome, and chronic myofascial pain syndrome. However, given documentation of ongoing treatment with Relafen, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Relafen use to date. Therefore, based on guidelines and a review of the evidence, the request for Relafen 750mg is medically necessary.