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| Case Number: | CM14-0043988 | | |
| Date Assigned: | 07/02/2014 | Date of Injury: | 10/21/2010 |
| Decision Date: | 09/09/2014 | UR Denial Date: | 03/28/2014 |
| Priority: | Standard | Application Received: | 04/11/2014 |

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 Medicine and is licensed to practice in North Carolina. 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 50 -year-old with a reported date of injury of 10/21/2010 that occurred when crawling in an attic and suffering a meniscal injury. The patient has the diagnoses of reflex sympathetic dystrophy of the lower limb and chronic pain syndrome. The treatment modalities have included surgery, lumbar sympathetic blocks and spinal cord stimulator. Per the progress notes provided by the requesting physician dated 03/17/2014, the patient had complaints of pain in the left knee, leg and foot with swelling. The physical exam noted decreased range of motion in the left leg, color changes of the left limb, left knee swelling and allodynia with hyperpathia in the left lower limb. Treatment recommendations included refill on medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Percocet 5/325mg #120 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 82.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids and neuropathic pain states "Opioids for neuropathic pain: Not recommended as a first-line

therapy. Opioid analgesics and Tramadol have been suggested as a second-line treatment (alone or in combination with first-line drugs). A recent consensus guideline stated that opioids could be considered first-line therapy for the following circumstances: (1) prompt pain relief while titrating a first-line drug; (2) treatment of episodic exacerbations of severe pain; [&] (3) treatment of neuropathic cancer pain." (Dworkin, 2007)"Response of neuropathic pain to drugs may differ according to the etiology of therapeutic pain. There is limited assessment of effectiveness of opioids for neuropathic pain, with short-term studies showing contradictory results and intermediate studies (8-70 days) demonstrating efficacy." (Eisenberg-Cochrane, 2006) (Eisenberg-JAMA, 2005) The results of short-term trials were mixed with respect to analgesia (less than 24 hours of treatment). Intermediate trials (average treatment duration of 28 days) showed statistical significance for reducing neuropathic pain by 20% to 30% (and 30% may be the threshold for describing a meaningful reduction of pain). The patient is already on a first line treatment choice for neuropathic pain; however there is a lack of quantitative documentation of improvement of pain or function on the opioid that would justify its continued use and thus the request is not medically necessary.

1 prescription of Tramadol 50mg #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 84.

Decision rationale: The California chronic pain medical treatment guidelines section on Tramadol states "Specific Opioids: Tramadol: A recent Cochrane review found that this drug decreased pain intensity, produced symptom relief and improved function for a time period of up to three months but the benefits were small (a 12% decrease in pain intensity from baseline). Adverse events often caused study participants to discontinue this medication, and could limit usefulness. There are no long-term studies to allow for recommendations for longer than three months." (Cepeda, 2006) "Similar findings were found in an evaluation of a formulation that combines immediate-release vs. extended release Tramadol. Adverse effects included nausea, constipation, dizziness/vertigo and somnolence." (Burch, 2007) Per the progress notes this was the first prescription for the medication. The guidelines states that the medication can be used up to three months for pain. Criteria has been documented and met in the progress notes. Therefore, this request is medically necessary.

1 prescription of Amitriptyline 10mg #90 with 2 refills: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13.

Decision rationale: The California chronic pain medical treatment guidelines section on antidepressants states: "Antidepressants for chronic pain Recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain." (Feuerstein, 1997) (Perrot, 2006) "Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur." (Saarto-Cochrane, 2005) Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. The requested medication is a tricyclic antidepressant and is a first line treatment choice in this patient with neuropathic pain and thus is considered medically necessary.

1 prescription of Lyrica 150mg #90 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin Page(s): 99.

Decision rationale: The California chronic pain medical treatment guidelines section on Pregabalin states: "Pregabalin (Lyrica) has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has FDA approval for both indications, and is considered first-line treatment for both. Pregabalin was also approved to treat fibromyalgia. CRPS: Gabapentin has been recommended." (Serpell, 2002) The requested medication is not indicated for the patient's diagnoses. There is also a failure of documentation of significant improvement while on this medication. For these reasons the request is not medically necessary.