

<b>Case Number:</b>	CM14-0166054		
<b>Date Assigned:</b>	10/13/2014	<b>Date of Injury:</b>	10/01/2001
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	09/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Colorado

Certification(s)/Specialty: Family Practice

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

50 year old male with date of injury 10/1/2001 continues care with the treating physician. Patient diagnoses include Lumbar Post-Laminectomy Syndrome, Myofascial pain, Lumbar Radiculopathy and Thoracic Radiculopathy. Patient has participated in Physical Therapy, Lumbar epidural steroid injections (25% relief), and multiple medications. Patient also had 3 lumbar procedures: L4-S1 Fusion August 2004, L5-S1 Fusion 2005, Revision of Left L5-S1 Laminectomy / Facetectomy March 2008. Despite all above interventions, patient continues to complain of pain, stabbing and aching in nature, in low back and legs. Per the records, no specific physical findings related to patient complaints are documented. The patient's medication regimen has included Topamax, Oxycodone and Oxymorphone in the past, and most recently includes Norco, Lyrica, Cymbalta, and Protonix. Per the records, patient did experience significant opiate addiction issues following his industrial injury treatment and has completed detoxification and functional rehabilitation program. The treating physician has requested Lyrica and Norco for ongoing management of pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 prescription of Lyrica 75mg #106:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 16-17 AND 19-20.

**Decision rationale:** Per the guidelines, no randomized controlled trials exist to recommend Lyrica, or other anti-epileptic drugs, for treatment of radiculopathy. When Lyrica is used for pain relief, "good" response can be defined as a 50% reduction in pain and a "moderate" response as a 30% reduction in pain. If patient does not achieve at least 30% improvement in pain, then changes should be considered: Switch to different first line agent or use Lyrica in combination with other agents. If therapy with Lyrica is initiated, the pain level, functional improvement or lack thereof and side effects should be followed and documented. Lyrica is FDA-approved for diabetic neuropathy and post-herpetic neuralgia. and is first-line treatment for both. Lyrica is also the first FDA-approved treatment for fibromyalgia. (ICSI,2007) (Tassone, 2007) (Knotkova, 2007) (Eisenberg, 2007) (Crofford, 2005) (Stacey, 2008). Per the records supplied for review, the patient has achieved some improvement in pain and function in the past with Lyrica. However, there is no documentation of percentage of improvement and no discussion of exactly what part of patient's symptoms complex improved. It is unclear from the record if Lyrica is being used for radiculopathy or other patient diagnosis, or combination. As Lyrica has no indication for or evidence to support its use in radiculopathy, and no documentation of good or moderate response in this patient, Lyrica is not medically indicated.

**1 prescription of Norco 10/325mg #240:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 79-80, 85, 88-89 AND 91.

**Decision rationale:** The Guidelines establish criteria for use of opioids, including long term use (6 months or more). When managing patients using long term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain / work / interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant / addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize the above, the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) Several circumstances need to be considered when determining to

discontinue opioids:1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient.3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function.4) Patient has evidence of unacceptable side effects.5) Patient's pain has resolved.6) Patient exhibits "serious non-adherence." Per the Guidelines, Chelminski defines "serious substance misuse" or non-adherence as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005)7) Patient requests discontinuing opioids.8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work. Has patient had improved function and decreased pain with the opioids. For the patient of concern, the treating physician reviews the 4a's at patient visits, and documents some objective evidence of improved function with medications. Pain levels remained constant through the record, 7-8/10 and patient's Norco use escalated from 6 Norco per day to 8 Norco per day without adequate explanation for the continued increase in need for opioid. (Short term increase in Norco occurred after dental extractions, but then patient never returned to previous levels of Norco use. Furthermore, patient has 2 urine drugs screens positive for substances not prescribed (THC and Ethyl alcohol metabolites on one and THC on another). Patient has history of opiate addiction and is here exhibiting signs of recurrent aberrant drug taking behavior. While the monitoring of pain and function is being documented, patient continues with pain and no evidence of improvement even with escalated dose of opioids. Patient has escalated his dose of opioids without prior consultation with treating physician, and has used other substances, not prescribed, in direct violation of medication agreement and the Guidelines. In this patient with history of opiate addiction and evidence of recurrent aberrant drug taking behavior, Norco is no longer considered medically necessary.