

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0005120 | | |
| Date Assigned: | 01/16/2015 | Date of Injury: | 09/18/2000 |
| Decision Date: | 03/18/2015 | UR Denial Date: | 01/05/2015 |
| Priority: | Standard | Application Received: | 01/09/2015 |

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: California, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 injured worker is a 48 year old male, who sustained an industrial injury on 09/18/2000. Medical records provided did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed with chronic lumbar pain, status post lumbar fusion revision, lumbar radiculopathy, and left ankle pain. Treatment and diagnostic studies to date has included magnetic resonance imaging, x-rays of the left ankle, urine drug screens, use of transcutaneous electrical nerve stimulation unit, and medication regimen of Norco, Naprosyn, Lunesta, and Xanax. Currently, the injured worker complains of chronic low back pain with radiation to the left leg and foot along with chronic intermittent left ankle pain. The pain is rated an eight out of ten. The treating physician requested the prescriptions of Percocet for better pain control, but does not indicate the reason for the requested treatment of Lyrica. On 01/02/2015 Utilization Review non-certified the prescriptions of Lyrica 100mg with a quantity of 60 and Percocet 10/325mg with a quantity of 240, noting the California Medical Treatment Utilization Schedule, Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lyrica 100mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-17.

Decision rationale: The patient presents with chronic low back pain with radiation into the left leg and foot. The current request is for Lyrica 100mg #60. In the most recent physician's report provided dated 9/25/14 (19) the treating physician does not request Lyrica. The MTUS guidelines state that AEDs are recommended for neuropathic pain. Outcome: A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. (Eisenberg, 2007) (Jensen, 2006) After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. In this case, the medical records provided do not provide supporting documentation as to why the physician is requesting continued use of Lyrica and no documentation of pain relief or improvement in function is provided. According to the utilization review report of 1/02/15 (3) the physician's report available for review was dated 3/12/14, which was not provided for this review. In that report, the physician reported no change after tapering off Lyrica. It is unclear why there is another request for Lyrica. Therefore, recommendation is for denial.

Percocet 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 Opioids Page(s): 74-96.

Decision rationale: The patient presents with chronic low back pain with radiation into the left leg and foot. The current request is for Percocet 10/325mg #240. The treating physician only comments that the patient was switched from Norco to Percocet and reports less sedation. The MTUS guidelines state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, there is no documentation of before or after pain scales, functional improvements or improvements in ADLs, and no discussion of side effects or aberrant behaviors. According to the utilization review the treating physician's report dated 3/12/14 the treating physician states that the patient is being switched from Norco to Percocet, but there is no measurement provided of functional improvement correlated to opiate use. The PTP then

increases percocet from 5/325 to 7.5/325. The current request is for Percocet 10/325 but there is no report justifying the increase from 7.5/325 to 10/325. Medical necessity has not been established. Recommendation is for denial.