

<b>Case Number:</b>	CM15-0032962		
<b>Date Assigned:</b>	02/26/2015	<b>Date of Injury:</b>	06/05/2003
<b>Decision Date:</b>	04/13/2015	<b>UR Denial Date:</b>	01/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/23/2015

### 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: New York  
 Certification(s)/Specialty: Anesthesiology

### 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 male patient, who sustained an industrial injury on 06/05/2003. A pain management visit dated 12/19/2014 reported subjective complaint of increased pain and discomfort. He continues to suffer with intractable pain on current medication regimen, which has been present for many years now. The patient is found using Opioids in the form of Fentanyl and Oxycontin along with Lyrica and Topamax, regularly. He is currently disabled. Physical examination found his lumbosacral vertebral spine as well as multiple tender areas and paraspinous muscle spasm at times. Unchanged from previous exams. Flexion is tolerated to 20 degrees and he has pain with lateral flexion/extension. The following diagnoses are applied; morbid obesity; chronic pain syndrome; lumbosacral spondylosis without myelopathy; lumbosacral neuritis; backache and opioid induced hyperalgesia. A request was made for Oxycontin 80mg # 90. On 01/27/2015, Utilization Review, non-certified the request, noting the CA MTUS, Chronic Pain Guidelines, Opioids was cited. On 02/23/2015, the injured worker submitted an application for independent medical review of requested services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Oxycontin 80mg 1 TID #90 monthly:** 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): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** According to ODG and MTUS, Oxycontin (Oxycodone) is a long-acting opioid analgesic, and is in a class of drugs that has a primary indication to relieve symptoms related to pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. There was no documentation of functional improvement from previous usage of opioids to consider continuation of this medication. In addition, there is no clear rationale or documentation for the use of two (2) long-acting opioids (Oxycontin and Duragesic). Medical necessity of the requested medication has not been established. Of note, discontinuation of an Oxycontin should include a taper, to avoid withdrawal symptoms. The certification of the requested medication is not recommended.

**Lyrica 150mg 1 BID #60, monthly:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica Page(s): 58.

**Decision rationale:** According to California MTUS Guidelines, anti-epilepsy medications are a first-line treatment for neuropathic pain. Lyrica is FDA approved for diabetic neuropathy and post-herpetic neuralgia and has been used effectively for the treatment of other neuropathic pain. This patient has been prescribed/taking Lyrica for many years for neuropathic pain/back pain, related to the work injury. The narcotic analgesics requested in this case are recommended for non-certification (and to be weaned). Medical necessity for the requested medication, Lyrica, has been established. The requested medication is medically necessary.

**Topamax 100mg 1QD HS #30, monthly:** 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): 16-21.

**Decision rationale:** Topamax (Topiramate) is an anti-epilepsy drug (AED) used for the treatment of neuropathic pain. It has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for

neuropathic pain when other anticonvulsants fail. In addition, this medication is used in the treatment of migraine prevention. In this case, there is no documentation of the any improvement in pain relief or functional benefit from the use of this medication. Medical necessity for the requested medication is not established. The requested medication is not medically necessary.

**Duragesic 100 transermal film, extended release, Apply 1 patch 72hrs #10, monthly:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Fentanyl transdermal patch (Duragesic) Page(s): 91-97; 93. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids; Fentanyl.

**Decision rationale:** According to ODG and MTUS, Fentanyl is a long-acting narcotic analgesic. Narcotic analgesics are generally classified according to potency and duration of dosage. Fentanyl is the most potent opiate available for use in medical treatment, 50 to 100 times more potent than morphine, and 30 to 50 times more potent than heroin. Duragesic transdermal patch (Fentanyl transdermal) is indicated for management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opiate therapy. Duragesic transdermal patches should only be used in patients who are currently on opiate therapy for which tolerance has developed. These are not for use in routine musculoskeletal pain. Patches are worn for a 72-hour period. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing narcotic analgesic therapy. In addition, there is no clear rationale or documentation for the use of two (2) long-acting opiates (Oxycontin and Duragesic). Medical necessity of the requested Duragesic transdermal patches has not been established. Of note, discontinuation of a narcotic analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.