

<b>Case Number:</b>	CM15-0045460		
<b>Date Assigned:</b>	03/17/2015	<b>Date of Injury:</b>	04/11/2002
<b>Decision Date:</b>	04/17/2015	<b>UR Denial Date:</b>	02/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2015

### 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: Internal Medicine

### 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 50 year old male, who sustained a work/ industrial injury on 4/11/02. He has reported initial symptoms of lumbar pain. The injured worker was diagnosed as having lumbar radiculopathy. Treatments to date included medication, epidural steroid injections, and surgery. Magnetic Resonance Imaging (MRI) reported s/p L5-S1 laminectomy and posterior interbody spinal fusion with normal alignments, left posterolateral disc osteophyte complex measuring at least 4 mm without nerve impingement, L4-5 annular bulge and facet arthropathy, and no disc herniation. Currently, the injured worker complains of lumbar pain reported at 6/10. The treating physician's report (PR-2) from 2/9/15 indicated tenderness over the lower lumbar facet joints, palpable spasm bilaterally at L1-L5 paraspinal muscles, positive straight leg raise on the left, normal strength in the lower extremities, decreased sensory sensation in the bilateral L5-S1 distribution, and normal tendon reflexes. Medications included Fentanyl patch, Nucynta IR, and Gralise. Treatment plan included refill of one (1) prescription of Nucynta 100mg #120 with 2 refills, One (1) prescription of Fentanyl patch 100mcg #10 with 2 refills, and One (1) prescription of Gralise 500mg with 2 refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) prescription of Nucynta 100mg #120 with 2 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97.

**Decision rationale:** According to MTUS, Nucynta is a centrally acting opioid analgesic and is in a class of drugs that has a primary indication to relieve symptoms related to pain. Opioid drugs are available in various dosage forms and strengths. They are considered the most powerful class of analgesics that may be used to manage both acute and chronic pain. These medications are generally classified according to potency and duration of dosage. 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, the patient has been prescribed Nucynta and, Fentanyl patch. There is no documentation of the Nucynta's pain relief effectiveness, functional improvement from previous usage, or response to ongoing opioid analgesic therapy. In addition the claimant's present daily dose of opioids exceeds the recommended Morphine Equivalent Dose (MED) for the treatment of nonmalignant pain. Medical necessity of the requested item has not been established. Of note, discontinuation of an Nucynta should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

**One (1) prescription of Fentanyl patch 100mcg #10 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 Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines: Fentanyl.

**Decision rationale:** Fentanyl is an opioid analgesic with a potency of eighty times that of Morphine. According to ODG, chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. According to ODG and MTUS, Fentanyl is a long-acting narcotic analgesic used to manage both acute and chronic pain. Fentanyl transdermal (DURAGESIC) patches are indicated for the management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. Duragesic patches should only be used in patients who are currently on opioid therapy for which tolerance has developed. Patches are worn for a 72-hour period. In this case, 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 addition the claimant's present daily dose of opioids exceeds the recommended Morphine Equivalent Dose (MED) for

the treatment of nonmalignant pain. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal. Medical necessity for the requested item is not established. The requested medication is not medically necessary.

**One (1) prescription of Gralise 500mg with 2 refills:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic drugs (AEDs) Page(s): 17-19. Decision based on Non-MTUS Citation Official Disability Guideline: Gabapentin.

**Decision rationale:** According to the CA MTUS (2009) and ODG, (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. The records documented that the patient has neuropathic pain related to his chronic low back condition. Neurontin has been part of his medical regimen and has proved beneficial. Medical necessity for the requested medication is established. The requested medication is medically necessary.