

<b>Case Number:</b>	CM14-0216532		
<b>Date Assigned:</b>	01/06/2015	<b>Date of Injury:</b>	05/31/2002
<b>Decision Date:</b>	03/04/2015	<b>UR Denial Date:</b>	12/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/26/2014

### 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: California

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:

According to the records made available for review, the injured worker is a 63 year-old male with a date of injury of 05/31/2002. The results of the injury include chronic lumbar spine pain. Diagnoses have included post-lumbar laminectomy syndrome; and cervical spondylosis and radiculopathy. Diagnostic studies included an MRI of the lumbar spine, dated 04/17/2013, which revealed disc herniation or disc extrusion at the T 11-12 level with superior and less so inferior migration from the disc space; and extensive fusion. An MRI of the cervical spine, dated 12/10/2007, was remarkable for congenital fusion of C2 and C3; grade I retrolisthesis of C4 and C5; and multilevel cervical spondylosis with central canal and foraminal narrowing. Treatments have included medications, TENS unit, home assistance; acupuncture treatments, chiropractic treatments, and surgical interventions. Medications have included Gabapentin, Oxycodone, Gralise, Lidoderm patches, and Kadian. Surgical interventions have included complete L2 and left L3-L5 laminectomies /foraminectomies; transforaminal interbody fusion L3-4, L4-5, and S1; and posterior spinal fusion T10-T12, with posterolateral fusion L1 to S1, performed on 09/23/2002. A progress note from the treating physician, dated 11/24/2014, documented a follow-up visit with the injured worker. The injured worker reported chronic pain in the neck, mid-back, lower back, buttock, and lower extremities; pain at 8/10 on the visual analog scale; pain reduction with the use of prescribed medications, allowing some ability to complete ADLs with assistance; and mild leg swelling. Objective findings included stasis dermatitis bilaterally of the lower extremities with pitting edema; gait stooped, cautious, unsteady; no tenderness to palpation of the lumbar paraspinal muscles, lumbar spinous processes, facet joints, SI joints

bilaterally, or of the piriformis muscle bilaterally. The plan of treatment includes resending referral for physical therapy; refills of medications; and follow-up visit in four weeks. Request is being made for a prescription for Kadian 50 mg tabs #60; a prescription for Oxycodone 5 mg #360; and a prescription for Gabapentin 300 mg #90. On 12/02/2014, Utilization Review non-certified a prescription for Kadian 50 mg tabs #60. Utilization Review non-certified a prescription for Kadian 50 mg tabs #60 based on excessive dosage; the mechanism of injury was not described; and the lack of documentation to support the prescribed dosage of this medication. Utilization Review non-certified a prescription for Oxycodone 5 mg #360. Utilization Review non-certified a prescription for Oxycodone 5 mg #360 based on the amount/dosage of this medication (12 a day) is not medical reasonable or necessary for breakthrough pain. Utilization Review non-certified a prescription for Gabapentin 300 mg #90. Utilization Review non-certified a prescription for Gabapentin 300 mg #90 based on non-clarity of the reason the medication is being prescribed. The Utilization Review cited the following evidence-based guidelines: Official Disability Guidelines Worker's Compensation Drug Formulary, [www.odgtwc.com/odgtwc/formulary.htm](http://www.odgtwc.com/odgtwc/formulary.htm); Goodman and Gilman's the Pharmacological Basis of Therapeutics, 12th Edition, 2010; Physician's Desk Reference, 68th Edition; [www.RxList.com](http://www.RxList.com); Epocrates Online, [www.online.epocrates.com](http://www.online.epocrates.com); Monthly Prescribing Reference, [www.empr.com](http://www.empr.com); Opioid Dose Calculator-AMDD Agency Medical Directors' Group Dose Calculator, [www.agencymeddirectors.wa.gov](http://www.agencymeddirectors.wa.gov). Application for independent medical review was made on 12/22/2014.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **3 Kadian 50mg tabs #60: Upheld**

**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 CRITERIA FOR USE OF OPIOIDS Page(s): 76-78,88-89.

**Decision rationale:** This patient presents with chronic, neck, low back pain. The current request is for Kadian 50 mg tabs; 1 tab p.o. b.i.d. #60, 30-day fill, 0 refills. For chronic opioid use, the MTUS Guidelines pages 88 and 89 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 adverse 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. Review of the medical file indicates the patient has been utilizing Kadian as early as 01/15/2013. According to progress report dated 05/05/2014, the patient has noted an increase of pain since stopping Lyrica. Otherwise, the patient reports Kadian and oxycodone provide him with "pain control." Current pain was rated as 8/10. Progress report dated 09/24/2014 notes the patient states that his medications continue to provide him with reasonable pain control and relief as needed with increase stability to complete ADLs with assistance. On 11/24/2014, the patient reported current pain as 8/10 and

states medication continue to help him and provide him with some ability to complete ADLs with assistance with no side effects to medications. In this case, recommendation for further use cannot be supported as the treating physician has provided no discussion regarding specific functional improvement, change in ADLs, or return to work status to document significant functional improvement. The patient continues to report current pain as 8/10 and requires assistance including a home healthcare nurse that provides assistance with ADLs and medication distribution. Furthermore, there is no discussion regarding possible aberrant behaviors, and urine drug screens were not discussed or provided. The treating physician has failed to provide the minimum requirements of documentation that are outlined in MTUS for continued opiate use. The requested Kadian IS NOT medically necessary.

**Oxycodone 5mg #360:** Upheld

**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 CRITERIA FOR USE OF OPIOIDS Page(s): 76-78,88-89.

**Decision rationale:** This patient presents with chronic, neck, low back pain. The current request is for oxycodone 5 mg tabs, 2 tabs p.o. q.4h #360, 30-day fill, 0 refills. For chronic opioid use, the MTUS Guidelines pages 88 and 89 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 adverse 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. Review of the medical file indicates the patient has been utilizing Oxycodone as early as 01/15/2013. According to progress report dated 05/05/2014, the patient has noted an increase of pain since stopping Lyrica. Otherwise, the patient reports Kadian and oxycodone provide him with "pain control." Current pain was rated as 8/10. Progress report dated 09/24/2014 notes the patient states that his medications continue to provide him with reasonable pain control and relief as needed with increase stability to complete ADLs with assistance. On 11/24/2014, the patient reported current pain as 8/10 and states medication continue to help him and provide him with some ability to complete ADLs with assistance with no side effects to medications. In this case, recommendation for further use cannot be supported as the treating physician has provided no discussion regarding specific functional improvement, change in ADLs, or return to work status to document significant functional improvement. The patient continues to report current pain as 8/10 and requires assistance including a home healthcare nurse that provides assistance with ADLs and medication distribution. Furthermore, there is no discussion regarding possible aberrant behaviors, and urine drug screens were not discussed or provided. The treating physician has failed to provide the minimum requirements of documentation that are outlined in MTUS for continued opiate use. The requested Oxycodone IS NOT medically necessary.

**Gabapentin 300mg tabs #90:** Upheld

**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 gabapentin(SPECIFIC ANTI-EPILEPSY DRUGS) Page(s): 18-19.

**Decision rationale:** This patient presents with chronic, neck, low back pain. The current request is for gabapentin 300-mg tabs, 1 tab p.o. t.i.d. #90, 30-day fill, 0 refills; for lumbar spine pain as an outpatient. The MTUS Guidelines page 18 and 19 has the following regarding gabapentin, Gabapentin has been shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered the first line treatment for neuropathic pain. This is an initial request for this medication. The utilization review denied the request. However, rationale for the denial was not provided for review. The patient has a diagnosis for cervical radiculopathy. However, there is no examination of the cervical spine. Examination of the lumbar spine is provided which provides no documentation of radicular symptoms for which this medication is intended for. The requested gabapentin IS NOT medically necessary.