



DATE OF REVIEW: March 23, 2010

IRO Case #:

Description of the services in dispute:

Item in dispute: Neurontin 600mg, Percocet 10–325mg, and Valium 10mg (00710401).

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician providing this review is board certified in Anesthesiology. The reviewer holds additional certification in Pain Medicine from the American Board of Pain Medicine. The reviewer is a diplomate of the National Board of Medical Examiners. The reviewer has served as a research associate in the department of physics at MIT. The reviewer has received his PhD in Physics from MIT. The reviewer is currently the chief of Anesthesiology at a local hospital and is the co-chairman of Anesthesiology at another area hospital. The reviewer has been in active practice since 1978.

Review Outcome

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

The Neurontin and diazepam cannot be considered to be medically necessary. The use of Percocet several times per day for the chronic pain is also questionable. In general, longer acting opioids are recommended for the treatment of chronic pain. Furthermore, there is no indication that standard protocols for chronic opioid administration, as listed below, are being followed.

Information provided to the IRO for review

Record Received from the State:

Letter from to Utilization Review, undated, 2 pages

Reconsideration result to Dr., 2/12/2010, 7 pages

reconsideration determination letter, 2/11/2010, 7 pages

To Whom It May Concern letter of 2/3/2010, Yvette (last name illegible), 1 page

Medical treatment determination (Review #51601), 1/27/2010, 4 pages

Determination letter 1/27/2010, 4 pages

Appeal request from patient, undated, 1 page

Records Received from Physician:

Precert request, 2/4/2010, 1 page

Prior authorization fax request to utilization review, 1/22/2010, 1 page

Follow up office note, Pinnacle Pain Medicine Dr., 1/21/2010, 1 page

Peer review, Solutions, 5/20/2009, 3 pages

Metropolitan Radiology, 4/16/2009, 1 page

MRI cervical spine authorization determination, 4/9/2009, 1 page

Clinic note, Dr., 1/7/2009, 2 pages

Peer review, Solutions, 12/9/2008, 8 pages

Progress note, Dr., 11/25/08, 1 pages

8/27/08 date of service, 1 page

Consultation letter, Dr., 8/27/2009, 2 pages

Fax cover from Rehabilitation Medical Specialist indicating CPT 8/27/2008, 9/18/2008, 1 page

EMG study, 8/27/2008, 2 pages

Hand Surgery Association, 7/29/2008, 3 pages

Rehabilitation Medical Specialists address change notification, 9/1/2006, 1 page

Patient clinical history [summary]

The claimant is a female who allegedly suffered a workplace injury on xx/xx/xx. Subsequently, she underwent an anterior discectomy and fusion at C6–7 for undisclosed symptoms. Since then she has suffered from neck and right arm pain that is worsened by repetitive motions. Physical examination reveals tenderness in the right arm and limitation of cervical range of motion. She is being treated with Neurontin, Percocet and diazepam, apparently given for sleep.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The submitted medical record does not substantiate a diagnosis of neuropathic pain associated with her post–laminectomy syndrome on the basis of physical findings, electrodiagnostic examination, or other objective findings. In fact, the presence of tenderness points to nociceptive pain. Neurontin is indicated only for neuropathic pain. The use of diazepam or any other benzodiazepine for an extended period of time is also not recommended because of the likelihood of the development of tolerance and serious withdrawal symptoms if the medication is discontinued. Based on this reasoning, the Neurontin and diazepam cannot be considered to be medically necessary. The use of Percocet several times per day for the chronic pain is also questionable. In general, longer acting opioids are recommended for the treatment of chronic pain. Furthermore, there is no indication that standard protocols for chronic opioid administration, as listed below, are being followed.

A description and the source of the screening criteria or other clinical basis used to make the

decision:

The following are steps to avoid misuse of opioids, and in particular, for those at high risk of abuse

- a) Opioid therapy contracts. See Guidelines for Pain Treatment Agreement.
- b) Limitation of prescribing and filling of prescriptions to one pharmacy.
- c) Frequent random urine toxicology screens.
- d) Frequent evaluation of clinical history, including questions about cravings for the former drug of abuse (a potential early sign of relapse).
 - e) Frequent review of medications (including electronic medical record evaluation when available and pill counts at each visit, brought in the original bottle from the pharmacy).
 - f) Communication with pharmacists.
 - g) Communication with previous providers and other current providers, with evidence of obtaining medical records. (It has been recommended that opioids should not be prescribed on a first visit until this step has been undertaken.)
 - h) Evidence of participation in a recovery program (12-step or follow-up with a substance abuse counselor), such as speaking to his/her sponsor for the 12-step program.
 - i) Establishment of goals of treatment that can be realistically achieved.
 - j) Initiation of appropriate non-opioid adjunct medications and exercise programs.
 - k) Utilize careful documentation, and in particular, that which is recommended in the State in which opioids are prescribed.
 - l) Incorporate family and friends for support and education.

Gabapentin is an anti-epilepsy drug (AEDs – also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. Anti-epilepsy drugs are recommended for neuropathic pain (pain due to nerve damage), but not for acute somatic pain. (Gilron, 2006) (Wolfe, 2004) (Washington, 2005) (ICSI, 2005) (Wiffen-Cochrane, 2005) (Attal, 2006) (Wiffen-Cochrane, 2007) (Gilron, 2007) (ICSI, 2007) (Finnerup, 2007) There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy. (Attal, 2006) The choice of specific agents reviewed below will depend on the balance between effectiveness and adverse reactions. See also specific drug listings below: Gabapentin (Neurontin®); Pregabalin (Lyrica®); Lamotrigine (Lamictal®); Carbamazepine (Tegretol®); Oxcarbazepine (Trileptal®); Phenytoin (Dilantin®); Topiramate (Topamax®); Levetiracetam (Keppra®); Zonisamide (Zonegran®); & Tiagabine (Gabitril®) Outcomes: 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. AEDs are associated with teratogenicity, so they must be used with caution in woman of childbearing age. Specifically studied disease states: (also see below for specific drugs).

Benzodiazepines – Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005)

ODG Treatment Index, Pain. Encinitas, CA: Work Loss Data Institute, 2010.