

Case Number:	CM13-0031056		
Date Assigned:	12/04/2013	Date of Injury:	06/16/2006
Decision Date:	01/17/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	10/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine, has a subspecialty in Pulmonary Diseases and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 40-year-old female who reported an injury on 06/16/2006 after a physical attack. The patient developed unilateral chronic regional pain syndrome in her right lower extremity. The patient's medications included a Duragesic patch 75 µg every 3 days, oxycodone immediate release 30 mg 4 tabs per day, Lyrica 200 mg 3 times a day, Neurontin 600 mg 3 times a day, 10 mg of trazodone at night, clonazepam 2 mg in the evening for anxiety, Robaxin 750 mg, and 8 mg of Rozerem at night. It was noted that the patient has functional improvement of approximately 50% with taking medications versus not taking them at all. The patient also has a reported pain level of 8/10. Physical findings included significant disuse atrophy of the right lower extremity, cold to touch sensation of the right lower extremity, and severe significant signs of allodynia of the right lower extremity. The patient's diagnoses included right lower extremity pain following open reduction and internal fixation procedure of the right ankle, development of severe complex regional pain syndrome, development of disuse atrophy in the right lower extremity, chronic insomnia due to pain, history of anxiety and depression with industrial onset, nocturnal leg cramps, claudication with industrial onset, and constipation with narcotic use. The patient's treatment plan was to continue medication management of the patient's chronic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duragesic patch 75mcg #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

Decision rationale: The requested Duragesic patch 75 $\hat{\mu}$ g 75 mcg (#10) is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has 8/10 pain with medication and 10/10 without medication. This is not a significant reduction in pain. California Medical Treatment and Utilization Schedule recommends opioids for the ongoing management of chronic pain be supported by a pain assessment supporting reduced pain as a result of medication usage, an assessment of increased functional benefit, assessment of side effects, and evidence of monitoring for compliance to the prescribed medication schedule. The clinical documentation submitted for review does provide evidence that the patient has some pain relief with the prescribed medication schedule. However, the documented level of pain relief would not be considered significant. The clinical documentation submitted for review does provide evidence that the patient does report 50% functional improvement with medication usage. However, this functional improvement is not objectively documented. Also, the clinical documentation does not include any evidence of monitoring for compliance to the prescribed medication schedule. There was no evidence of a pain contract, pill counts, or regular assessment of aberrant or non-adherent behaviors. As such, the requested Duragesic patch 75 $\hat{\mu}$ g is not medically necessary or appropriate.

Oxycodone IR 30mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

Decision rationale: The requested oxycodone IR 30 mg #120 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has 8/10 pain with medication and 10/10 without medication. This is not a significant reduction in pain. California Medical Treatment and Utilization Schedule recommends opioids for the ongoing management of chronic pain be supported by a pain assessment supporting reduced pain as a result of medication usage, an assessment of increased functional benefit, assessment of side effects, and evidence of monitoring for compliance to the prescribed medication schedule. The clinical documentation submitted for review does provide evidence that the patient has some pain relief with the prescribed medication schedule. However, the documented level of pain relief would not be considered significant. The clinical documentation submitted for review does provide evidence that the patient does report 50% functional improvement with medication usage. However, this functional improvement is not objectively documented. Also, the clinical documentation does not include any evidence of monitoring for compliance to the prescribed medication schedule. There was no evidence of a pain contract, pill

counts, or regular assessment of aberrant or non-adherent behaviors. As such, the requested oxycodone IR 30 mg is not medically necessary or appropriate.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Zolpidem

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Zolpidem.

Decision rationale: The requested Ambien 10 mg is not medically necessary or appropriate. The clinical documentation does support that the patient has minimal pain relief as a result of her prescribed medications. It is noted in the documentation that she does suffer from insomnia related to her injury. Official Disability Guidelines do recommend insomnia be addressed for patients with chronic pain. However, zolpidem or Ambien is only recommended for short-term use for the treatment of insomnia. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration. There are no exceptional factors within the documentation to support extending treatment beyond guideline recommendations. Additionally, it is noted that the patient is also on trazadone 10 mg and Rozerem 8 mg to treat the patient's insomnia and pain. It is unclear why the patient requires multiple insomnia medications, as the patient's sleep hygiene is not addressed within the documentation. As such, the requested Ambien 10 mg #30 is not medically necessary or appropriate.

Lyrica 200mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

Decision rationale: The requested Lyrica 200 mg #90 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has minimal pain relief as a result of her prescribed medication schedule. California Medical Treatment and Utilization Schedule does recommend Lyrica for the treatment of neuropathic pain. California Medical Treatment and Utilization Schedule does recommend the use of medications for the treatment of chronic pain to be supported by an assessment of pain relief and increased functional capabilities. The clinical documentation does not clearly identify increased functional benefit as it is related to this medication. Additionally, it is noted that the patient is also on Neurontin 600 mg 3 times a day. The clinical documentation does not clearly identify why the use of both of these medications is necessary to treat the patient's pain. As such, the requested Lyrica 200 mg #90 is not medically necessary or appropriate

Clonazepam 1mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: The clinical documentation does indicate the patient has minimal pain relief as a result of the prescribed medication schedule. California Medical Treatment and Utilization Schedule does recommend the use of benzodiazepines, such as clonazepam for the short-term treatment of anxiety related to pain. However, the clinical documentation submitted for review does indicate that the patient has been on this medication for an extended period of time. The clinical documentation submitted for review does not provide an assessment of symptom response to this medication. Therefore, the efficacy of clonazepam is not established. Additionally, as this medication is only recommended for short-term use, continuation would not be supported. As such, the requested clonazepam 1 mg #30 is not medically necessary or appropriate