

<b>Case Number:</b>	CM13-0037801		
<b>Date Assigned:</b>	01/22/2014	<b>Date of Injury:</b>	02/22/1996
<b>Decision Date:</b>	05/28/2014	<b>UR Denial Date:</b>	09/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/24/2013

### 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. The expert reviewer is Board Certified in Occupational Medicine 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 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/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 applicant is a represented [REDACTED] employee who has filed a claim for reflex sympathetic dystrophy and chronic pain syndrome reportedly associated with an industrial injury of February 22, 1996. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; sleep aid; long and short-acting opioids; spinal cord stimulator implantation; and psychotropic medications for derivative depression. In a Utilization Review Report of September 20, 2013, the claims administrator denied the request for Ambien while partially certifying Duragesic, oxycodone, and OxyContin, seemingly for weaning purposes. The applicant's attorney subsequently appealed. A clinical progress note of December 2, 2013, is notable for comments that the applicant reports persistent pain complaints about the bilateral upper extremities, low back, and bilateral lower extremities, ranging from 5.5/10 with medications to 10/10 without medications. The applicant states that he is limited in terms of various activities of daily living, including self-care, personal hygiene, activity, ambulating, hand function, and sleep. The applicant is apparently non-ambulatory and using a wheelchair. A spinal cord stimulator battery is appreciated about the left upper chest. The applicant is described as "permanently disabled." It is stated there has been interval worsening in the applicant's condition over the preceding six (6) months, despite earlier epidural injections, medications, physical therapy, and spine surgery. Numerous medications, including Keppra, Mobic, Topamax, oxycodone, Ambien, Lidoderm, Duragesic, OxyContin, and Prozac are endorsed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**AMBIEN 10MG #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), TREATMENT INDEX, 11TH EDITION (WEB), 2013, PAIN-ZOLPIDEM (AMBIEN)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), CHRONIC PAIN CHAPTER, ZOLPIDEM.

**Decision rationale:** The Official Disability Guidelines indicate that zolpidem (Ambien) is recommended for the short-term management of insomnia, typically on the order of two to six (2-6) weeks. It is not recommended for chronic, long-term, and/or scheduled purposes, for which it is being proposed here. Therefore, the original utilization review decision is upheld. The request remains not certified, on Independent Medical Review.

**FENTANYL PATCH 75MG/HR #10:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines DURAGESIC (FENTANYL TRANSDERMAL SYSTEM) AND OPIOIDS, CRITERIA FOR.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE, Page(s): 80.

**Decision rationale:** Fentanyl or Duragesic is a long-acting opioid. The Chronic Pain Medical Treatment Guidelines indicate that the cardinal criteria for the continuation of opioid therapy include evidence of successful return to work, improved functioning, and/or reduced pain achieved as a result of ongoing opioid usage. In this case, however, these criteria have not been met. The applicant has seemingly failed to return to work and has been deemed permanently disabled by her primary treating provider. The applicant report heightened pain and heightened difficulty performing activities of daily living. Ongoing usage of fentanyl and/or other opioids has not been effective. Therefore, the request is likewise not certified, on Independent Medical Review.

**OXYCODONE HCL 5MG #300:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE AND OPIOIDS Page(s): 76-80, 91-94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE Page(s): 80.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines indicate that the cardinal criteria for the continuation of opioid therapy include evidence of a successful return to work, improved functioning, and/or reduced pain as a result of ongoing opioid usage. As with the other

opioids, the applicant has failed to meet criteria. Specifically, the applicant has failed to return to work. The applicant has been deemed as permanently disabled by her primary treating provider. The applicant has failed to accomplish the required inability to show pain and/or improved performance of activities of daily living with ongoing opioid usage. The attending writes on the most recent December 2013 progress note that the applicant's ability to perform numerous basic activities of daily living is limited, despite ongoing opioid usage. The applicant's pain complaints are likewise heightened as opposed to reduced. Continuing opioid therapy is not indicated, for all of the stated reasons. Accordingly, the request is likewise not certified, on Independent Medical Review.

**OXYCONTIN 40MG #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE AND OPIOIDS, OXYCODONE Page(s): 76-80, 9.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE AND OPIOIDS Page(s): 78, 80.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines indicate that the lowest possible dose of opioid should be prescribed to improve pain and function. In this case, the attending provider has not clearly stated why two (2) separate long-acting opioids, namely fentanyl and OxyContin, are needed or indicated here. It is further noted that, as with the other agents, the applicant has failed to meet the criteria based on the Guidelines for the continuation of opioid therapy. Specifically, the applicant has failed to return to work. The applicant has been deemed permanently disabled by her primary treating provider. The applicant's pain complaints are heightened as opposed to reduced, despite ongoing opioid therapy. The applicant's ability to perform numerous basic activities of daily living appears limited, despite ongoing opioid therapy. Continuing the same is not indicated, for all of the stated reasons. Therefore, the request is not certified, on Independent Medical Review.