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| Case Number: | CM13-0048181 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 07/18/2001 |
| Decision Date: | 03/27/2014 | UR Denial Date: | 10/28/2013 |
| Priority: | Standard | Application Received: | 11/04/2013 |

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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:

This case involves a 42-year-old female with a 7/18/2001 industrial injury claim. She has been diagnosed with chronic lumbosacral injury secondary to status post 2-level fusion with hardware removal; polypharmacy with associated tachyarrhythmias and small atrial septal defect and chronic spinal pain; positional tachycardia related to multiple medication complication; decompensation with discontinuation of atenolol with anterior chest wall pain consistent with myocardial ischemia; and enlarged lymph nodes on a cervical MRI. The claimant also has chronic pain syndrome. On 10/28/13, the Utilization Review (UR) modified the use of Fentanyl, as the requested dose exceeds the recommended guideline for 72-hour use; denied Zanaflex; modified Lunesta to one month without refill; modified temazepam to allow weaning; modified alprazolam to allow weaning; and denied Phenergan

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl 100mcg, #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug test Page(s): 93.

Decision rationale: The Chronic Pain Guidelines indicate that Fentanyl transdermal is indicated for the management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. According to the 10/4/13 report from [REDACTED], the patient presents with low back pain and postural orthostatic tachycardic syndrome. The back pain is rated 6/10. She has decreased sensation to light touch at the S1 and L5 dermatomes. She is severely deconditioned. Fentanyl 100mcg/hr was prescribed every other day, #15. The guidelines indicate that Fentanyl patches are worn for 72-hours. The dosing for every 48-hours is not in accordance with the guidelines.

Zanaflex 4mg #90, with three (3) refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/antispasmodic drugs and Pain Outcomes and Endpoints Page(s): 66,8-9.

Decision rationale: According to the 10/4/13 report from [REDACTED], the patient presents with low back pain and postural orthostatic tachycardic syndrome. The back pain is rated 6/10. She has decreased sensation to light touch at the S1 and L5 dermatomes. She is severely deconditioned. The patient's labs on 2/13/13 show liver enzymes in normal ranges. The earliest report available for Independent Medical Review (IMR) from [REDACTED] is dated 1/30/13, and shows that the patient was taking Zanaflex at that time, and on every report up through 10/4/13. None of the available reports discuss the efficacy of Zanaflex. The Chronic Pain Guidelines indicate, "All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement." The guidelines also indicate, "When prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." There is no reporting on the efficacy of the medications, and the documentation does not support a satisfactory response. There is no mention of improved pain, or improved function or improved quality of life with the use of Zanaflex. The guidelines do not recommend continuing treatment if there is not a satisfactory response

Lunesta 3mg #30, with three (3) refills: 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), Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Outcomes and Endpoints Page(s): 8-9. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Online for insomnia treatment (<http://www.odg-twc.com/odgtwc/pain.htm#Insomniatreatment>)

Decision rationale: According to the 10/4/13 report from [REDACTED], the patient presents with low back pain and postural orthostatic tachycardic syndrome. The back pain is rated at 6/10. She has decreased sensation to light touch in the S1 and L5 dermatomes. She is severely deconditioned. The patient's labs on 2/13/13 show liver enzymes in normal ranges. The earliest report available for Independent Medical Review (IMR) from [REDACTED] is dated 1/30/13, and shows the patient was taking Lunesta at that time and on every report up through 10/4/13. None of the available reports discuss the efficacy of Lunesta. The Chronic Pain Guidelines indicate, "All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement." The guidelines also indicate, "When prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." There is no reporting on efficacy of the medications, the documentation does not support a satisfactory response. There is no mention of improved pain, or improved function or improved quality of life with the use of Lunesta. The guidelines do not recommend continuing treatment if there is not a satisfactory response.

Temazepam 30mg #30, with three (3) refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: According to the 10/4/13 report from [REDACTED], the patient presents with low back pain and postural orthostatic tachycardic syndrome. The back pain is rated at 6/10. She has decreased sensation to light touch in the S1 and L5 dermatomes. She is severely deconditioned. The patient's labs on 2/13/13 show liver enzymes in normal ranges. The earliest report available for Independent Medical Review (IMR) from [REDACTED] is dated 1/30/13, and shows the patient was taking Temazepam at that time and on every report up through 10/4/13. The Chronic Pain Guidelines specifically states benzodiazepines are not recommended for use over four (4) weeks. The continued use of temazepam over nine (9) months will continue to exceed the guideline recommendations

Alprazolam 2mg #90, with three (3) refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: According to the 10/4/13 report from [REDACTED], the patient presents with low back pain and postural orthostatic tachycardic syndrome. The back pain is rated at 6/10. She has decreased sensation to light touch in the S1 and L5 dermatomes. She is severely deconditioned. The patient's labs on 2/13/13 show liver enzymes in normal ranges. The earliest

report available for Independent Medical Review (IMR) from [REDACTED] is dated 1/30/13, and shows the patient was taking alprazolam at that time and on every report up through 10/4/13. The Chronic Pain Guidelines specifically states benzodiazepines are not recommended for use over four (4) weeks. The continued use of alprazolam over nine (9) months will continue to exceed the guideline recommendations.

Phenergan 25mg/ml solution #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), Pain (Chronic).

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

Decision rationale: According to the 10/4/13 report from [REDACTED], the patient presents with low back pain and postural orthostatic tachycardic syndrome. The back pain is rated at 6/10. She has decreased sensation to light touch in the S1 and L5 dermatomes. She is severely deconditioned. Phenergan has been used for nausea from medications. The Official Disability Guidelines specifically states: "Not recommended for nausea and vomiting secondary to chronic opioid use." The request is not in accordance with the guidelines.