

<b>Case Number:</b>	CM13-0072015		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	07/18/2001
<b>Decision Date:</b>	08/04/2014	<b>UR Denial Date:</b>	12/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2013

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain 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 patient is a 41 year old female who was injured on 07/18/2001. She noted a cumulative trauma injury going back over several months involving low back pain related to work activities. Prior treatment history has included physical therapy, chiropractic treatment, lumbar epidural injections, acupuncture treatment, aquatic therapy, and lumbar median nerve blocks bilaterally; the patient underwent anterior lumbar discectomy and decompression at L4-5 and L5-S1 with fusion and instrumentation on 06/14/2006. She was returned to the operating room on 06/16/2006 for posterior lumbosacral pedicle screw fixation and stabilization at L4-S1. On 02/01/08 she underwent removal of posterior segmental hardware and exploration of the fusion. Diagnostic studies reviewed include MRI lumbar spine dated 07/12/2007 showing postsurgical and degenerative changes. An MRI of the lumbar spine dated 10/30/2001 revealed L5-S1 degenerative changes with facet arthropathy. There was noted slight spondylolisthesis with discogenic neural change. CT scan of lumbar spine dated 12/19/2001 revealed a mild bulge with minimal facet arthropathy at L3-4, a disc bulge at L4-5 with small right paracentral protrusion and bilateral facet arthropathy and L5-S1 left paracentral protrusion with bilateral facet arthropathy. Progress Report dated 12/04/2013 documented the patient to have complaints of back pain, low back pain and lumbar complaints with associated stiffness. Objective findings on exam Gait and station exam reveals midposition without abnormalities. Muscle strength for all groups is 5-/5. Inspection of the skin outside affected area reveals no abnormalities. S12 dermatome and L5 dermatome demonstrates decreased light touch sensation bilaterally. Examination of the lumbar spine reveals pain with valsalva, positive Faber maneuver bilateral, positive Patrick's maneuver, positive pelvic rock maneuver bilateral, pain to palpation over the L4 to L5 and L5 to S1 facet capsules bilateral, pain with rotational extension indicative of facet capsula tears and secondary myofascial pain with triggering bilateral and this is again worse than

last evaluation. She is again severely deconditioned. Assessment: 1.Status post two-level fusion with hardware removal. 2.Polypharmacy with associated tachyarrhythmia apparently with small atrial septal defect and chronic spine pain. 3.Positional tachycardia, likely related to multiple medication complications. 4.Decompression with discontinuation of atenolol with anterior chest wall pain consistent with myocardial ischemia. Treatment Plan: 1.Alprezolan 2 mg. 2.Dronabinol 5 mg. 3.Fentanyl 100 mcg. 4.Fiorinal 50/325 mg. 5.Lunesta 3 mg. 6.Nuvgil 250 mg. 7.Norco 10-325mg. 8.Percocet 325 mg. 9.Sumatriptan 100 mg. 10.Temazepam 30 mg. 11.Zanaflex 4 mg.

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

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

#### **FENTANYL 100MCG/HR #15: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system) Page(s): 44.

**Decision rationale:** Duragesic (fentanyl transdermal system)Not recommended as a first-line therapy. Duragesic is the trade name of a fentanyl transdermal therapeutic system, which releases fentanyl, a potent opioid, slowly through the skin. It is manufactured by ALZA Corporation and marketed by Janssen Pharmaceutica (both subsidiaries of Johnson & Johnson). The FDA-approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means.Fentanyl is an opioid analgesic with potency eighty times that of morphine. This strong opioid medication has the potential of significant side effects. The medical records do not establish non-opioid analgesics are not sufficiently appropriate to address this patient's pain complaints. The medical records do not establish the patient requires continues opioid analgesia that cannot be managed by other means.

#### **16 ACUPUNCTURE SESSIONS: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** (1) "Acupuncture" is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. (1)Time to produce functional improvement: 3 to 6 treatments. (2)Acupuncture treatments may be extended if functional improvement is documented. The medical records demonstrate the patient's past treatment has included acupuncture treatment. The guidelines state Acupuncture treatments may be extended if functional improvement is documented. However, the medical records do not establish the patient obtained clinically significant benefit with the previous course of acupuncture, such as reduction in medication use and decreased pain level and increased function. In addition, the medical records do not establish the patient is currently participating in a program of physical rehabilitation or recently undergone surgical intervention. Consequently, the medical necessity of additional

acupuncture has not been established.

**16 PHYSICAL THERAPY SESSIONS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 134.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**Decision rationale:** The medical records demonstrate the patient's treatment history has included supervised physical therapy. The guidelines state physical therapy treatments may be extended if functional improvement is documented. However, the medical records do not establish the patient obtained clinically significant benefit with the previous course of therapy, such as reduction in medication use and decreased pain level and increased function. In addition, it is not established that the patient presents with a clinically significant exacerbation or new injury as would necessitate a return to supervised therapy. It is reasonable that the patient should be versed in an independent home exercise program with which to utilize on a routine basis to maintain function. The medical records do not establish the patient has tried to follow a self-care program. The medical necessity for physical therapy is not been established at this time.

**PERCOCET 5/325 MG #360: 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 list Page(s): 74-96; 74-80.

**Decision rationale:** The medical records indicate the patient has had multiple medication complications likely the result of polypharmacy. The guidelines state continuation of opioids is recommended if the patient has returned to work and if the patient has improved functioning and pain. The medical records do not demonstrate either return to work or improvement in function and pain with opioid use. Ongoing opioid usage, in the absence of clinical findings substantiating moderate to moderately severe pain is not supported. Percocet is therefore not medically necessary.

**NORCO 10/325 MG #360: 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 list, page(s) ; Opioids, page(s) 74-80 Page(s): 74-96; 74-80.

**Decision rationale:** The patient has been prescribed Norco 10/325 and Percocet 5/325. These opioids are of the same class, short-acting opioids, and are indicated for moderate to moderately severe pain. According to the guidelines, they are often used for intermittent or breakthrough pain, and are often combined with other analgesics such as acetaminophen and aspirin. The guidelines do not recommend simultaneous opioid usage. Regarding on-going management, the guidelines state, the lowest possible dose should be prescribed to improve pain and function. It is appropriate and supported by the guidelines that the lowest dosage is provided, and higher dosages would only be considered if the first-line intervention is not successful. The medical necessity of Norco has not been established.

**LUNESTA 3 MG #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).

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

**Decision rationale:** ODG: Eszopicolone (Lunesta) - Not recommended for long-term use, but recommended for short-term use. The medical records submitted do not document any subjective complaints or corroborative clinical objective findings as to establish an active diagnosis of insomnia. It is also relevant that the medical records do not document the patient's attempts to establish and maintain appropriate sleep hygiene. According to the referenced guidelines, Lunesta is indicated short-term treatment of insomnia; however, as the diagnosis of insomnia is not evident, the medical necessity of Lunesta is not established.

**TEMAZEPAM 30 MG # 30:** 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:** Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. According to the guidelines, Temazepam is not recommended. Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Benzodiazepines are a major cause of overdose, particularly as they act synergistically with other drugs such as opioids. The guidelines states Benzodiazepines are the treatment of choice in very few conditions. The medical records do not provide a clinical rationale that establishes the necessity for a medication not recommended under the evidence-based guidelines. The medical necessity of Temazepam has not been established.

**ALPRAZOLAM 2 MG #90:** 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 guidelines, Xanax is a short-acting drug of the benzodiazepine class used to treat moderate to severe anxiety disorders, panic attacks, and as an adjunctive treatment for anxiety associated with major depression. It is not recommended for long-term use. The medical records do establish the patient has any of the conditions for which this medication may be considered appropriate to treat. Benzodiazepines are not recommended because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Benzodiazepines are a major cause of overdose, particularly as they act synergistically with other drugs such as opioids. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Based on these factors, the medical necessity of Alprazolam is not established.

**PSYCH CONSULTATION:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398, Chronic Pain Treatment Guidelines Psychological evaluations Page(s): 100-101.

**Decision rationale:** According to the referenced guidelines, a psych consult may be recommended based upon a clinical impression of psychological condition that impacts recovery, participation in rehabilitation, or prior to specified interventions. The references state specialty referral may be necessary when patients have significant psychopathology or serious medical comorbidities. The medical records do not reveal detailed documentation of psych-related subjective complaints with corroborating clinical findings and observations as to support medical necessity for psychological consultation. The medical necessity of a psych consult has not been established.