MAXIMUS Federal Services

Case Number:	CM14-0103384		
Date Assigned:	09/15/2014	Date of Injury:	10/25/2005
Decision Date:	10/15/2014	UR Denial Date:	06/19/2014
Priority:	Standard	Application Received:	07/03/2014

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 Family 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:

Patient is a 55-year-old female who has submitted a claim for cervical failed back syndrome, lumbar failed back syndrome, cervical radiculopathy, nondependent tobacco use disorder, fibromyalgia, hypertension, Crohn's disease, and iron deficiency anemia associated with an industrial injury date of 10/25/2005.Medical records from 2014 were reviewed. The patient complained of constant, achy, and burning neck pain, associated with numbness to both trapezius. Patient likewise had numbness and tingling sensation of the low-back area. Pain medications helped to decrease the pain. Pain severity was rated 6 to 7/10. Back pain was rated 2/10 in severity. Patient likewise had intermittent left shoulder pain, and limited motion of the right shoulder secondary to pain. Patient reported bilateral wrist pain, aggravated by prolonged typing. She had low back pain, without numbness or tingling sensation. Physical examination showed diffuse tenderness and spasm of the paracervical area. Restricted motion of the cervical spine was noted. Deep tendon reflex of right biceps was rated 1+. Tenderness was also noted at the left shoulder and left biceps tendon. Bilateral shoulder range of motion was limited. Motor strength of left upper extremities was graded 4/5. Tinel's sign was positive on both wrists, as well as Finkelstein test. Examination of the lumbar spine showed tenderness and limited motion. Sensation was intact. Weakness was noted at the left extensor hallucis longus and anterior tibialis. Left ankle jerk was graded 1+.Treatment to date has included cervical fusion, left foot surgery, physical therapy, and medications such as Atenolol, Cyclobenzaprine, Dilaudid, Effexor, Fioricet, Klonopin, Oxcarbazepine, Oxycodone (since 2011), Flector patch (since 2011), and Zanaflex (since 2011).Utilization review from 6/20/2014 denied the requests for Fentanyl 75mcg patch #15 and Fentanyl 75mcg #15 because there was no pain level present to validate increased severity of symptoms; denied Oxycodone 20mg #120, Oxycodone 20mg #120, and Oxycodone 30mg #120 because of no documentation of efficacy with prior use of this

medication; denied Flector 1.3% patch #60 because of no evidence that patient had failed Wellbutrin; denied Fioricet 50mg/325mg #60, Fioricet 50/325 mg #60, and Fioricet 50/325mg #90 because the guidelines did not recommend this medication and there was no evidence of benefit from medication use; and modified the request for Zanaflex 4mg #90 into #20 because there was evidence of muscle spasm, however, the guidelines only recommended use of muscle relaxant for two weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl 75mcg patch #15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic; Opioids, Fentanyl (transdermal), Page(s): 44; 78; 93.

Decision rationale: Page 44 of CA MTUS Chronic Pain Medical Treatment Guidelines states that "Duragesic (Fentanyl transdermal system) is not recommended as a first-line therapy. Furthermore, page 93 also states that Duragesic is indicated for management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy that cannot be managed by other means (e.g., NSAIDS). There are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. In this case, there is limited medical record available for review; hence, the initial prescription date of Fentanyl patch is unknown. Patient is likewise on Oxycodone and there is no discussion as to why adjuvant therapy with Fentanyl patch is necessary. Moreover, there is no documentation concerning pain relief and functional improvement derived from its use. The medical necessity cannot be established due to insufficient information. Therefore, the request for Fentanyl 75mcg patch #15 is not medically necessary.

Oxycodone 20mg #120: Upheld

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

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

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on Oxycodone since 2011. However, the medical records do

not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. Urine drug screen is likewise not available for review. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request for Oxycodone 20mg #120 is not medically necessary.

Flector 1.3% patch #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Page(s): 46. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Flector Patch).

Decision rationale: As stated on page 46 of the California MTUS Chronic Pain Medical Treatment guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. Pages 111-112 of CA MTUS Chronic Pain Medical Treatment Guideline state that topical NSAIDs, such as Diclofenac (Flector patch), have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. In addition, FDA indications for Flector patches include acute strains, sprains, and contusions. In this case, patient has been on Flector patch since 2011. However, there is no documentation concerning pain relief and functional improvement derived from its use. Long-term use is likewise not recommended. Therefore, the request for Flector 1.3% patch #60 is not medically necessary.

Fioricet 50mg/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-Containing Analgesics Page(s): 23.

Decision rationale: Fioricet contains Butalbital, Acetaminophen, and Caffeine. As stated on page 23 of the California MTUS Chronic Pain Medical Treatment Guidelines, barbiturate-containing analgesic agents are not recommended for chronic pain. There is no clinical evidence concerning the analgesic efficacy of barbiturate-containing analgesics. In this case, there is limited medical record submitted for review; hence, the initial prescription date of Fioricet is unknown. There is no documentation available concerning functional improvements derived from this medication. Fioricet is not recommended for chronic pain. There is no discussion concerning the need for variance from the guidelines. Therefore, the request for Fioricet 50/325mg, #60 is not medically necessary.

Fentanyl 75mcg #15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic; Opioids Fentanyl (transdermal) Page(s): 44; 78; 93.

Decision rationale: Page 44 of CA MTUS Chronic Pain Medical Treatment Guidelines states that "Duragesic (Fentanyl transdermal system) is not recommended as a first-line therapy. Furthermore, page 93 also states that Duragesic is indicated for management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy that cannot be managed by other means (e.g., NSAIDS). There are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. In this case, there is limited medical record available for review; hence, the initial prescription date of Fentanyl patch is unknown. Patient is likewise on Oxycodone and there is no discussion as to why adjuvant therapy with Fentanyl patch is necessary. Moreover, there is no documentation concerning pain relief and functional improvement derived from its use. The medical necessity cannot be established due to insufficient information. Therefore, the request for Fentanyl 75mcg patch #15 is not medically necessary.

Oxycodone 20mg #120: Upheld

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

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

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on Oxycodone since 2011. However, the medical records do not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. Urine drug screen is likewise not available for review. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request for Oxycodone 20mg #120 is not medically necessary.

Fioricet 50/325 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-Containing Analgesics Page(s): 23.

Decision rationale: Fioricet contains Butalbital, Acetaminophen, and Caffeine. As stated on page 23 of the California MTUS Chronic Pain Medical Treatment Guidelines, barbiturate-containing analgesic agents are not recommended for chronic pain. There is no clinical evidence concerning the analgesic efficacy of barbiturate-containing analgesics. In this case, there is limited medical record submitted for review; hence, the initial prescription date of Fioricet is unknown. There is no documentation available concerning functional improvements derived from this medication. Fioricet is not recommended for chronic pain. There is no discussion concerning the need for variance from the guidelines. Therefore, the request for Fioricet 50/325mg, #60 is not medically necessary.

Fioricet 50/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-Containing Analgesics Page(s): 23.

Decision rationale: Fioricet contains Butalbital, Acetaminophen, and Caffeine. As stated on page 23 of the California MTUS Chronic Pain Medical Treatment Guidelines, barbiturate-containing analgesic agents are not recommended for chronic pain. There is no clinical evidence concerning the analgesic efficacy of barbiturate-containing analgesics. In this case, there is limited medical record submitted for review; hence, the initial prescription date of Fioricet is unknown. There is no documentation available concerning functional improvements derived from this medication. Fioricet is not recommended for chronic pain. There is no discussion concerning the need for variance from the guidelines. Therefore, the request for Fioricet 50/325mg, #90 is not medically necessary.

Oxycodone 30mg #120: Upheld

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

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

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on Oxycodone since 2011. However, the medical records do not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. Urine drug screen is likewise not available for review. MTUS Guidelines require clear

and concise documentation for ongoing management. Therefore, the request for Oxycodone 30mg #120 is not medically necessary.

Zanaflex 4mg #20: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Page(s): 63.

Decision rationale: According to page 63 of the CA MTUS Chronic Pain Medical Treatment Guidelines, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, the patient has been on Zanaflex since 2011. However, there is no documentation concerning pain relief and functional improvement derived from its use. Long-term use is likewise not recommended. There is no discussion concerning need for variance from the guidelines. Therefore, the request for Zanaflex 4 mg, #20 is not medically necessary.