

<b>Case Number:</b>	CM14-0012415		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	04/13/2000
<b>Decision Date:</b>	07/30/2014	<b>UR Denial Date:</b>	01/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2014

### 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 Physical Medicine and Rehabilitation 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 underlying date of injury in this case is 04/13/2000. The patient's diagnoses include chronic low back pain with a postlaminectomy syndrome, history of lumbar fusion from L3 through S1 posteriorly and L3 and L4 anteriorly, myofascial pain, depression, opioid dependency/tolerance. On 12/19/2013, the patient was seen in management reevaluation. The patient reported that the medications had not been approved for the last 4 months and that the patient could not afford to pay for the medications which were being prescribed which kept her functional. The patient was requesting Norco until after surgery. Current medications which had been prescribed included Fentanyl, Fentora, Soma, Trazodone, Valium, Wellbutrin, and Zanaflex. Informed consent was reestablished for medical management. The treating provider planned to continue a Fentanyl patch at 100 mcg per hour and to continue/increase Norco 10/325 and to continue/hold Fentora at 500 mcg b.i.d. and to continue Soma, continue Cymbalta, continue Zanaflex, continue Valium, and continue Trazodone and Wellbutrin. An initial physician review noted that while medications were reported to keep the patient functional, there was no clear documentation of efficacy such as a measurable decrease in pain level or functional ability of the patient with the use of multiple medications. The review notes that there were multiple prior physician reviews which recommended additional information regarding the indications and benefit of multiple medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE/PROSPECTIVE REQUEST FOR PRESCRIPTION OF NORCO  
10/325MG, #150: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Hydrocodone/Acetaminophen).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids/Ongoing Management Page(s): 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on opioids/ongoing management, page 78, discusses in detail the four A's of opioid management, including the need to establish specific measurable goals prior to treatment and to monitor efficacy towards such functional goals during treatment. The medical records do not meet these four A's of opioid management. This patient has been treated with extensive dosages of opioids without clear functional benefit. This treatment is not medically necessary.

**RETROSPECTIVE/PROSPECTIVE REQUEST FOR PRESCRIPTION OF SOMA #90:  
Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol/Soma Page(s): 29.

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on Carisoprodol/Soma, page 29, states that this medication is not recommended and is not indicated for long-term use. This medication particularly is not indicated in conjunction with opioid medications which have been prescribed in this case. The medical records do not provide an alternate rationale for the use of this medication. This request is not medically necessary.

**RETROSPECTIVE/PROSPECTIVE REQUEST FOR PRESCRIPTION OF CYMBALTA  
60MG, #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cymbalta Page(s): 30.

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines state regarding this medication that it is FDA approved for anxiety, depression, neuropathic pain, and radiculopathy. This patient does have multiple diagnoses for which this medication may be useful. However, the medical records do not clearly

indicate benefit from past use or a means of monitoring its ongoing indication or benefit in a chronic timeframe. Therefore, given this limited clinical information to support its use, this request is not medically necessary.

**RETROSPECTIVE/PROSPECTIVE REQUEST FOR PRESCRIPTION OF ZANAFLEX 4MG, #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 66.

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on muscle relaxants, page 66, state regarding Zanaflex that it is unlabeled for low back pain and that some authors recommended its use as a first-line option to treat myofascial pain. This medication, therefore, may have some indication for chronic back pain if there is specific documentation of the rationale and efficacy of its use. Such documentation is not present in this case. This request is not medically necessary.

**RETROSPECTIVE/PROSPECTIVE REQUEST FOR PRESCRIPTION OF VALIUM 10MG, #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 19.

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on benzodiazepines, state that this class of medications is not recommended for long-term use and benzodiazepines are the treatment of choice in very few conditions chronically. The medical records do not provide alternate rationale to support the use of this medication chronically. This request is not medically necessary.

**RETROSPECTIVE/PROSPECTIVE REQUEST FOR PRESCRIPTION OF TRAZODONE 100MG, #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13.

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on antidepressant for chronic pain, page 13, recommend

consideration of this class of medications. The medical records in this case do not clearly document a means of following the efficacy of this medication or a rationale for its use. Without further information regarding efficacy, this is not supported by the guidelines. This request is not medically necessary.

**RETROSPECTIVE/PROSPECTIVE REQUEST FOR PRESCRIPTION OF WELLBUTRIN XL 300MG, #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants (For Chronic Pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Bupropion/Wellbutrin Page(s): 27.

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on Bupropion/Wellbutrin, page 27, state that this is recommended as an option after other agents and that this is generally a third-line medication for diabetic neuropathy and may be considered when patients have not had a response to a tricyclic or serotonin norepinephrine reuptake inhibitor. Thus, this medication is indicated in only very specific clinical circumstances which are not documented in this case. At this time, based on the available information, this request is not medically necessary.

**RETROSPECTIVE/PROSPECTIVE REQUEST FOR PRESCRIPTION OF ABSTRAL 600UGM, #96: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids/Ongoing Management Page(s): 78. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA-approved labeling/Abstral.

**Decision rationale:** The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on opioids/ongoing management, page 78, discusses in detail the four A's of opioid management, including the need to establish specific measurable goals prior to treatment and to monitor efficacy towards such functional goals during treatment. The medical records do not meet these four A's of opioid management. This patient has been treated with extensive dosages of opioids without clear functional benefit. This treatment is not medically necessary. Additionally, FDA-approved labeling information states that this medication is indicated specifically for the management of breakthrough pain in cancer patients. This clinical situation does not apply. It is not clear why this treatment would be appropriate or indicated for this patient. This request is not medically necessary.