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| <b>Case Number:</b>   | CM14-0135893 |                              |            |
| <b>Date Assigned:</b> | 09/03/2014   | <b>Date of Injury:</b>       | 01/20/2005 |
| <b>Decision Date:</b> | 09/30/2014   | <b>UR Denial Date:</b>       | 08/12/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/22/2014 |

### 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 & 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 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 58 year old with an injury date on 1/20/05. Treater states that patient's pain has not changed in 6 consecutive progress reports from 2/5/14 to 8/7/14. In the most recent progress report dated 1/8/14 with details of subjective pain, patient complains of continued cervical pain, and increased pain in upper right extremity. Patient's pain level is a 9-10/10, but with medications it is reduced to 3-4/10 per 8/7/14 report. Based on the 8/7/14 progress report provided by [REDACTED] the diagnoses are: 1. cervical spine disease from injury. Continued pain despite cervical spinal surgery. Multi-factorial pain secondary to progressive degenerative disease from her injury, accelerated arthritis, and reactive soft tissue disease. 2. situational depression secondary to #1 Exam on 8/7/14 showed "severely decreased range of motion of C-spine. Upper extremities showed pain with manipulation of shoulders but no motor/sensory deficits." [REDACTED] is requesting ambien #15, soma #90, oxycodone #120, and fentanyl patch #30. The utilization review determination being challenged is dated 8/12/14. [REDACTED] is the requesting provider, and he provided treatment reports from 5/1/13 to 9/10/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien #15:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Ambien.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC guidelines, Chronic Pain Chapter, Insomnia Treatment, for Ambien states.

**Decision rationale:** This patient presents with neck pain and right arm pain. The treater has asked for ambien #15 on 8/7/14. Patient has been taking Ambien since 8/8/13. Regarding Ambien, ODG guidelines recommend for the short-term treatment (2 to 6 week period) of insomnia with difficulty of sleep onset (7-10 days). Not recommended for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. In this case, the patient has been taking Ambien for nearly a year, but ODG only recommends for short term use (7-10 days). The requested ambien #15 is not considered medically necessary.

**Soma #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma); Muscle Relaxants Page(s): 29; 63-66.

**Decision rationale:** This patient presents with neck pain and right arm pain. The treater has asked for soma #90 on 8/7/14. Patient has been taking soma since 5/1/13 report. Regarding Soma, MTUS does not recommend for longer than a 2 to 3 week period. Abuse has been noted for sedative and relaxant effects. In this case, the patient has been using Soma for more than 15 months, but MTUS only recommends for 2-3 weeks. The requested Soma #90 is not medically necessary for this patient's condition.

**Oxycodone #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78.

**Decision rationale:** This patient presents with neck pain and right arm pain. The treater has asked for oxycodone #120 on 8/7/14. Patient has been taking Oxycodone since 5/1/13 report. Patient has not worked since May 2006 per 7/30/10 QME. Review of records do not show patient has returned to work. For chronic opioids use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain

relief. In this case, the treater indicates a decrease in pain with current medications which include the opiate, but there are no discussion of this medication's efficacy in terms of functional improvement, quality of life change, or increase in activities of daily living. Given the lack of sufficient documentation regarding chronic opiates management as required by MTUS, the request is not medically necessary.

**Fentanyl Patch #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (Fentanyl Transdermal System).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system); Fentanyl; Fentora (fentanyl buccal tablet); Opioids, specific drug list Page(s): 44; 47; 47; 91-94.

**Decision rationale:** This patient presents with neck pain and right arm pain. The treater has asked for fentanyl patch #30 on 8/7/14. Patient has been using fentanyl patches since 5/1/13 report. Regarding Duragesic, ODG does not recommend 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. 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. Regarding medications for chronic pain, MTUS pg. 60 states treater must determine the aim of use, potential benefits, adverse effects, and patient's preference. Only one medication should be given at a time, a trial should be given for each individual medication, and a record of pain and function should be recorded. In this case, patient has been using Duragesic for 15 months and does not describe functional improvement from its use. Due to a lack of a discussion regarding the aim of use, potential benefits, and adverse effects of Duragesic, the request tis not medically necessary.