

<b>Case Number:</b>	CM14-0147977		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	12/15/2006
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	09/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2014

### 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:

Clinical Summary: The patient is a 49 year old female who was injured on 12/15/2006 while lifting. Prior medication history included Fentanyl patches 50 mcg, Dilaudid 8 mg, Imitrex 50 mg, Amitriptyline 100 mg, Soma 350 mg, Celexa 20 mg, Seroquel 50 mg, Baclofen 10 mg and trazodone 50 mg. Toxicology report dated 05/01/2014 detected Fentanyl which is consistent with medication prescribed. There were no other detections documented. On note dated 01/08/2014, the patient is noted to be taking the listed medications above and comes in with complaints of persistent low back pain with radiation into both her lower extremities. On exam, she had ongoing tenderness to the lumbar paraspinal muscles. Progress report dated 08/18/2014 states the patient presented with complaints of ongoing low back pain. On exam, there were no significant findings documented as her symptoms were unchanged from previous report. The patient was diagnosed with low back pain status post coccyx fracture with coccyx removal surgically in 2008; and depression and anxiety. She was prescribed Fentanyl 50 mcg #15, Imitrex 50 mg #9; trazodone 50 mg #60; Soma 350 mg #60; Celexa 20 mg; Dilaudid 8 mg; Seroquel, Baclofen, and Amitriptyline. Prior utilization review dated 09/03/2014 states the request for Fentanyl Patches 50mcg #15 for a 3-6 months' supply; Imitrex 50mg #9, for a 3-6 month supply; Trazodone 50mg #60, for a 3-6 month supply; Soma 350mg #60, for a 3-6 month supply; Celexa 20mg #30, for a 2 month supply; and Dilaudid 8mg #180, for a 3-6 month supply.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Fentanyl Patches 50mcg #15 for a 3-6 months supply: Upheld**

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

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

**Decision rationale:** The CA MTUS guidelines state Fentanyl is an opioid analgesic with a potency eighty times that of morphine. Fentanyl transdermal (Duragesic) is indicated for management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy, and the pain cannot be managed by other means (e.g., NSAIDs). Guidelines indicate "four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids; pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. 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 establish failure of non-opioid analgesics, such as NSAIDs, and there is no mention of ongoing attempts with non-pharmacologic means of pain management. There is little to no documentation of any significant improvement in pain level (i.e.VAS) or function with prior use to demonstrate the efficacy of this medication. The medical documents do not support continuation of opioid pain management. Therefore, the medical necessity for Fentanyl has not been established based on guidelines and lack of documentation.

**Imitrex 50mg #9, for a 3-6 month supply:** 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 Chapter, Migraine Medication

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Triptan Page(s): 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head, Triptan. Other Medical Treatment Guideline or Medical Evidence:  
<http://www.drugs.com/imitrex.html>

**Decision rationale:** CA MTUS /ACOEM/ODG do not address the issue. Imitrex (Sumatriptan) is a headache medicine that narrows blood vessels around the brain. Imitrex also reduces substances in the body that can trigger headache pain, nausea, sensitivity to light and sound, and other migraine symptoms. Imitrex is used to treat migraine headaches. Imitrex will only treat a headache that has already begun. In this case, there is no documentation of history of migraine or any migraine symptoms. Therefore, the request is not medically necessary and appropriate.

**Trazodone 50mg #60, , for a 3-6 month supply:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressant (for chronic pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Insomnia treatments

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti depressants for chronic pain Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Anti depressant for chronic pain.

**Decision rationale:** CA MTUS guidelines do not specifically discuss the issue in dispute and hence ODG have been consulted. As per ODG, Trazodone is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. In this case, this Injured Worker (IW), there is evidence of depression. However, there is no documentation of insomnia refractory to first line treatment. There is no documentation of a thorough evaluation to rule out other etiologies of sleep disturbance. Proper sleep hygiene is critical to the individual with chronic pain, which has not been addressed. ODG indicates there is no clear-cut evidence to recommend trazodone first line to treat primary insomnia. There is no documentation of significant improvement with prior use. Moreover, the IW is also taking Seroquel, Celexa and Amitriptyline. Thus, the criteria for Trazodone is not medically necessary and appropriate.

**Soma 350mg #60 , for a 3-6 month supply:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Muscle Relaxants

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (For pain) Page(s): 63-66.

**Decision rationale:** Per guidelines, muscle relaxants are recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic Low Back Pain (LBP) .Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Carisoprodol is now scheduled in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. In regular abusers the main concern is the accumulation of meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. This includes the following: (1) increasing sedation of benzodiazepines or alcohol; (2) use to prevent side effects of cocaine; (3) use with tramadol to produce relaxation and euphoria; (4) as a combination with hydrocodone, an effect that some abusers claim is similar to heroin (referred to as a "Las Vegas Cocktail"); & (5) as a combination with codeine (referred to as "Soma Coma"). In this case, there is no evidence of substantial spasm, refractory to first line therapy. There is no documentation of any significant improvement with continuous use. Long term use of

antispasmodics is not recommended. Therefore, the request is not medically necessary and appropriate.

**Celexa 20mg #30 , for a 2 month supply:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressant for chronic pain Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain

**Decision rationale:** Per guidelines, Celexa is not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. Selective serotonin reuptake inhibitors (SSRIs), a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline, are controversial based on controlled trials. It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. More information is needed regarding the role of SSRIs and pain. SSRIs have not been shown to be effective for low back pain. In this case, the IW is noted to have depression. She is also taking Seroquel and Amitriptyline. There is no evidence of any significant improvement of depression, pain or function with prior use of this medication. Therefore, the request is not medically necessary per guidelines.

**Dilaudid 8mg #180 , for a 3-6 month supply:** 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): 76-96.

**Decision rationale:** Dilaudid (Hydromorphone) is a short-acting opioid which is used for the management of moderate to severe pain. Guidelines indicate "four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids; pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors)." The guidelines state continuation of opioids is recommended if the patient has returned to work and if the patient has improved functioning and pain. There is little to no documentation of any significant improvement in pain level (i.e. VAS) or function with prior use to demonstrate the efficacy of this medication. A recent urine drug test result was inconsistent with use of this medication. Moreover, conversion to long acting opioids should be considered when continuous around the clock use of short acting opioids are required. Therefore, the medical necessity of request has not been established based on guidelines.