MAXIMUS Federal Services

Case Number:	CM14-0156706		
Date Assigned:	09/26/2014	Date of Injury:	10/07/2003
Decision Date:	10/30/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/24/2014

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 Preventive 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:

According to the records made available for review, this is a 55-year-old male with a 10/07/03 date of injury. At the time (7/31/14) of request for authorization for Amitriptyline 100 mg #30, Fentanyl 100 Mcg/Hr transdermal patch #15, Nucynta 100 mg #150, and Tegaderm 3 1/2" X 4" bandage #30, there is documentation of subjective (neck pain) and objective (decrease cervical range of motion, noted spasms, tenderness over the cervical paravertebral region, positive Spurling test, and diminished sensation in the C5 and C7 distribution) findings, current diagnoses (failed back syndrome, cervical degenerative disc disease, and displaced cervical disc with myelopathy), and treatment to date (medications (including ongoing treatment with Norco, Amitriptyline, Fentanyl patch, and Nucynta since at least 4/7/14), treatment with H-wave unit, medial branch injection, and epidural steroid injection). Medical report identifies that pain medications decrease pain and improve function. Regarding Fentanyl patch, there is no documentation of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient is already receiving opioid therapy, has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Fentanyl 25 mcg/h; and no contraindications exist. Regarding Nucynta, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and intolerable adverse effects with first line opioids. Regarding Tegaderm bandage, there is no documentation of a condition/diagnosis (with supportive subjective/objective) for which Tegaderm bandage is indicated (wounds).

IMR ISSUES, DECISIONS AND RATIONALES

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

AMITIPTYLINE 100 MG #30: Overturned

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): 13-14. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain, as criteria necessary to support the medical necessity of antidepressants. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies tricyclic antidepressants as first-line agent unless they are ineffective, poorly tolerated, or contraindicated. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of failed back syndrome, cervical degenerative disc disease, and displaced cervical disc with myelopathy. In addition there is documentation of chronic pain and ongoing treatment with Amitriptyline. Furthermore, given documentation that Amitriptyline decreases pain and improves function, there is documentation of functional benefit and improvement as an increase in activity tolerance as a result of Amitriptyline use to date. Therefore, based on guidelines and a review of the evidence, the request for Amitriptyline 100 mg #30 is medically necessary.

FENTANYL 100 MCG/HR TRANSDERMAL 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 Guidelines Duragesic (fentanyl transdermal system Page(s): 44. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Duragesic and Fentanyl Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20; and FDA

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means, as criteria necessary to support the medical necessity of Fentanyl. MTUS Chronic Pain Medical Treatment Guidelines identifies that Fentanyl is not recommended as first-line therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation that Fentanyl is not for use in routine

musculoskeletal pain. FDA identifies documentation of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient is already receiving opioid therapy, has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Fentanyl 25 mcg/h; and no contraindications exist, as criteria necessary to support the medical necessity of Fentanyl patch. Within the medical information available for review, there is documentation of diagnoses of failed back syndrome, cervical degenerative disc disease, and displaced cervical disc with myelopathy. In addition, there is documentation of pain and ongoing treatment with Fentanyl patch. Furthermore, given documentation that Fentanyl decreases pain and improves function, there is documentation of functional benefit and improvement as an increase in activity tolerance as a result of Fentanyl use to date. However, despite documentation of pain, there is no documentation of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient is already receiving opioid therapy, has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Fentanyl 25 mcg/h; and no contraindications exist. Therefore, based on guidelines and a review of the evidence, the request for Fentanyl 100 mcg/Hr transdermal patch #15 is not medically necessary.

NUCYNTA 100 MG #150: 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): 74-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Tapentadol (Nucynta) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of Opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of Nucynta used as a second line therapy for patients who develop intolerable adverse effects with first line opioids, as criteria necessary to support the medical necessity of Nucynta. Within the medical information available for review, there is documentation of diagnoses of failed back syndrome, cervical degenerative disc disease, and displaced cervical disc with myelopathy. In addition, there is documentation of ongoing treatment with Nucynta. Furthermore, given documentation that Nucynta decreases pain and improves function, there is documentation of functional benefit and improvement as an increase in activity tolerance as a result of Nucynta use to date. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, despite

documentation that Nucynta is used as a second line treatment, there is no documentation of intolerable adverse effects with first line opioids. Therefore, based on guidelines and a review of the evidence, the request for Nucynta 100 mg #150 is not medically necessary.

TEGADERM 3 1/2" X 4" BANDAGE #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: http://solutions.3m.com/wps/portal/3M/en_EU/Healthcare-Europe/EU-Home/Products/SkinWoundCare/WoundManagement/TegadermMatrix

Decision rationale: MTUS and ODG do not address the issue. Medical Treatment Guideline identifies documentation of a condition/diagnosis (with supportive subjective/objective) for which Tegaderm bandage is indicated (such as wounds), as criteria necessary to support the medical necessity of Tegaderm bandage. Within the medical information available for review, there is documentation of diagnoses of failed back syndrome, cervical degenerative disc disease, and displaced cervical disc with myelopathy. However, there is no documentation of a condition/diagnosis (with supportive subjective/objective) for which Tegaderm bandage is indicated (wounds). Therefore, based on guidelines and a review of the evidence, the request for Tegaderm 3 1/2" X 4" bandage #30 is not medically necessary.