

<b>Case Number:</b>	CM14-0157776		
<b>Date Assigned:</b>	10/01/2014	<b>Date of Injury:</b>	07/07/2004
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	09/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2014

### 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 Colorado. 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:

61year old male, already permanent and stationary from injury 7/7/2004, continues follow up with treating physician. Patient has chronic neck and low back pain with radicular symptoms to arms off and on. Patient also has documented anxiety issues. Diagnoses per the progress notes provided: Cervical Disc Disease with Myelopathy, Thoracic Disc Displacement, Lumbar Disc Displacement, Failed Back Syndrome. Notes supplied do not indicate any surgical history for back or neck. Patient has been on opioids long term, per the records, and dosing noted to be Percocet 5-6 tablets per day and Norco up to 4 tablets per day. He has also, at least intermittently, received non-steroidal anti-inflammatory drugs for pain relief. Patient has had fairly stable pain over time, per the notes, with increased lumbar pain with activity. Patient also has continued anxiety which is addressed briefly in the records supplied, and new onset sleep problems at the time Seroquel was requested. No further information on mood or other psychiatric symptoms is available for review. Patient has been taking Cymbalta and Trazodone for more than 6 months at the time of the Seroquel request. The treating physician is requesting Percocet for ongoing pain relief and Seroquel for sleep.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Long term users of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Pain Interventions and Treatments, Page(s): 79-80, 85, 88-89.

**Decision rationale:** The Guidelines establish criteria for use of opioids, including long term use (6 months or more). When managing patients using long term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. (Information from sources other than patient can also be considered.) Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain / work / interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant / addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize, the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. 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. Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient. Per the Guidelines, Chelminski defines "serious substance misuse" as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005) 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits "serious non-adherence" (including urine drug testing negative for prescribed substances on 2 occasions). 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue opioids. While the above patient has returned to work and has had somewhat improved function documented at some of his visits, no validated measuring tool was used to quantify the functional improvement. Also, he meets other criteria to discontinue opioids. Improvement in pain has not been well established in the records provided, even with multiple medications for pain including 2 short acting opioids. Though no urine drug testing reports were included in the records provided for review, one of the review records supplied does reference 2 urine drug tests, 4/2/2013 and 11/3/2013, that were negative for Percocet which patient was supposed to be taking several times per day at the time tested. No documentation was supplied or referenced as to if and how those urine drug tests were addressed and /or if further testing was ever completed. Without evidence that patient has improved with regard to function and pain, with the opioids, and with evidence of non-adherence, the Percocet refill request is not medically indicated. Furthermore, no weaning prescription would be needed

because patient has other opioids on order, and has no recent verification he has been taking Percocet regardless. Therefore this request is not medically necessary.

**Seroquel 50mg #30 with 1 refill:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines); Mental Illness & Stress (acute & chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 25, Stress Related Disorders page(s) 1055, 1058-1059 [www.fda.gov/.../advisorycommittees](http://www.fda.gov/.../advisorycommittees) "FULL PRESCRIBING INFORMATION"

**Decision rationale:** California MTUS Guidelines do not address Seroquel use, so other guidelines, namely the ACOEM Guidelines and FDA website, were consulted. Per the ACOEM, initial assessment and appropriate disposition of the patient are important to safely and effectively manage patients with stress related and/or psychiatric symptoms. The initial assessment should focus on identifying possible "red flags" that could represent risk for serious psychiatric disorder. If "red flags" are noted, then urgent Mental Health consult is warranted. If no "red flags" are noted, the Occupational Medicine Provider or Primary Care Provider can manage patient. Sleep disturbance is included in the "red flags," per the ACOEM, which would warrant referral for mental health assessment. Relief of stress-related symptoms depends on the origins of the stress, often multifactorial, and can involve interventions at home and at work. Medications generally have a limited role in stress-related symptoms, but medications can be needed more urgently and long term in true psychiatric disorders. The ACOEM recommends limited / short term use of anxiolytics. Furthermore, while antidepressants and antipsychotics would certainly be appropriate if major depression or psychosis are diagnosed, the guidelines recommend specialty referral if those medications are needed / considered. Patients under stress are encouraged to avoid inappropriate coping mechanisms including excessive use of alcohol, tobacco, or other drugs, or excessive food intake. These patients are also encouraged to work on exercise, relaxation techniques and cognitive behavioral adjustment. Per the ACOEM, referral to mental health may be considered if it is determined that patient will require more than 1 week off from work because of stress-related symptoms. If symptoms become disabling or persist for more than three months, referral to a mental health professional is indicated. Patient has chronic anxiety (length of time present unknown) as noted by the treating physician at 2/17/2014 visit. Per the records supplied, patient has been on Trazodone and Cymbalta for more than 6 months with persistent anxiety. Treating physician then noted increased sleep difficulty as well on 6/4/2014, and planned to discontinue Trazodone, start Seroquel "for sleep," and taper off Cymbalta while starting Fetzima. Patient has had persistent symptoms despite therapy with 2 antidepressants for more than 6 months. In addition, he now has a new symptom of sleep disturbance, a "red flag" symptom per ACOEM, so should be referred for specialty care. Per FDA, Seroquel has no indication for treatment specifically of insomnia unless it is comorbid with acute schizophrenia, bipolar mania, or bipolar depression, none of which have been diagnosed in patient. Given the above, the request for Seroquel is not medically necessary.