

Case Number:	CM14-0167311		
Date Assigned:	10/14/2014	Date of Injury:	06/14/1990
Decision Date:	11/17/2014	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/10/2014

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 69-year-old male with a 6/14/90 date of injury. At the time (9/15/14) of request for authorization for Benadryl Allergy 25mg #90 with 1 refill, Alprazolam 0.25mg #16 with 1 refill, Hydrocodone BT Ibuprofen 7.5/200mg #120 with 1 refill, and Duragesic patches 100mcg/hr #10, there is documentation of subjective (moderate to severe back pain) and objective (antalgic gait on the left) findings, current diagnoses (lumbar/lumbosacral degenerative intervertebral disc, post laminectomy syndrome, and thoracic/lumbosacral neuritis), and treatment to date (medications (including ongoing treatment with Benadryl, Alprazolam, Hydrocodone BT Ibuprofen, and Duragesic patches since at least 5/19/14)). Medical reports identify a decrease in pain level with medication use. Regarding Benadryl Allergy 25mg #90 with 1 refill, there is no documentation of insomnia, the intended duration of therapy with Benadryl, and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Benadryl use to date. Regarding Alprazolam 0.25mg #16 with 1 refill, there is no documentation of intention to treat over a short course (up to 4 weeks) and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Alprazolam use to date. Regarding Hydrocodone BT Ibuprofen 7.5/200mg #120 with 1 refill, 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 functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Hydrocodone BT Ibuprofen use to date. Regarding Duragesic patches 100mcg/hr #10, 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 has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Duragesic 25 mcg/h; and no contraindications exist; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Duragesic patch use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Benadryl Allergy 25mg #90 with 1 refill: 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, Insomnia

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Diphenhydramine (Benadryl) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations.

Decision rationale: MTUS does not address this issue. 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 states sedating antihistamines are not recommended for long-term insomnia treatment. Within the medical information available for review, there is documentation of a diagnosis of lumbar/lumbosacral degenerative intervertebral disc, post laminectomy syndrome, and thoracic/lumbosacral neuritis. However, there is no documentation of insomnia and the intended duration of therapy with Benadryl. In addition, given documentation of ongoing treatment with Benadryl and despite documentation of a decrease in pain level with medication use, there is no (clear) documentation 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 as a result of Benadryl use to date. Therefore, based on guidelines and a review of the evidence, the request for Benadryl Allergy 25mg #90 with 1 refill is not medically necessary.

Alprazolam 0.25mg #16 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that benzodiazepines are not recommended for long-term and that most guidelines limit use to 4 weeks. 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 a diagnosis of lumbar/lumbosacral degenerative intervertebral disc, post laminectomy syndrome, and thoracic/lumbosacral neuritis. However, given documentation of records reflecting prescriptions for Alprazolam since at least 5/19/14, there is no documentation of intention to treat over a short course (up to 4 weeks). In addition, given documentation of ongoing treatment with Alprazolam and despite documentation of a decrease in pain level with medication use, there is no (clear) documentation 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 as a result of Alprazolam use to date. Therefore, based on guidelines and a review of the evidence, the request for Alprazolam 0.25mg #16 with 1 refill is not medically necessary.

Hydrocodone BT Ibuprofen 7.5/200mg #120 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. 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 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. Within the medical information available for review, there is documentation of a diagnosis of lumbar/lumbosacral degenerative intervertebral disc, post laminectomy syndrome, and thoracic/lumbosacral neuritis. 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, given documentation of ongoing treatment with Hydrocodone BT Ibuprofen and despite documentation of a decrease in pain level with medication use, there is no (clear) documentation 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 as a result of Hydrocodone BT Ibuprofen use to date. Therefore, based on guidelines and a review of the evidence, the request for Hydrocodone BT Ibuprofen 7.5/200mg #120 with 1 refill is not medically necessary.

Duragesic patches 100mcg/hr #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system) Page(s): 44.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment 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 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 Duragesic. MTUS Chronic Pain Medical Treatment Guidelines identifies that Duragesic 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 Duragesic 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 Duragesic 25 mcg/h; and no contraindications exist, as criteria necessary to support the medical necessity of Duragesic patch. Within the medical information available for review, there is documentation of a diagnosis of lumbar/lumbosacral degenerative intervertebral disc, post laminectomy syndrome, and thoracic/lumbosacral neuritis. In addition, there is documentation of ongoing treatment with Duragesic patch, that Duragesic patch is not used as first-line therapy, and the patient is already receiving opioid therapy. However, despite documentation of moderate to severe pain, there is no (clear) documentation of persistent, moderate to severe chronic pain. In addition, given documentation of ongoing treatment with opioids, there is no documentation of 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 has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Duragesic 25 mcg/h; and no contraindications exist. In addition, given documentation of ongoing treatment with Duragesic patch and despite documentation of a decrease in pain level with medication use, there is no (clear) documentation 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 as a result of Duragesic patch use to date. Therefore, based on guidelines and a review of the evidence, the request Duragesic patches 100mcg/hr #10 is not medically necessary.