

<b>Case Number:</b>	CM15-0003075		
<b>Date Assigned:</b>	01/14/2015	<b>Date of Injury:</b>	12/16/1994
<b>Decision Date:</b>	03/10/2015	<b>UR Denial Date:</b>	12/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 injured worker is a 51 year old female, who sustained an industrial injury on December 16, 1994. She has reported low back pain. The diagnoses have included post-laminectomy pain syndrome. Treatment to date has included spinal fusion, laminectomy, medications, epidural steroid injections, physical therapy, acupuncture, transcutaneous electrical nerve stimulation, and spinal cord stimulation. On December 8, 2014, her pain is noted to be stable. Currently, the IW complains of left lower back pain with radiation down the left leg. Physical findings on December 29, 2014, are noted as tenderness over the back, limited range of motion in all directions, decreased sensation to light touch over the left thigh, and foot, decreased strength with left knee extension, Piriformis stretch is positive, and Trochanteric bursa tenderness on the left. The records indicate she was taken off of Gabapentin due to headaches, she had increased range of motion from physical therapy, and was started to be weaned off Duragesic. On December 16, 2014, Utilization Review non-certified the request for Duragesic 25 mcg, quantity #30, and Percocet 75/325 mg, quantity #120, and Ambien 10 mg, quantity #15, based on Chronic Pain Medical Treatment, ODG, and non-MTUS guidelines. On January 6, 2015, the injured worker submitted an application for IMR for review of Duragesic 25 mcg, quantity #30, and Percocet 75/325 mg, quantity #120, and Ambien 10 mg, quantity #15. The application lists the primary diagnosis as thoracic region radiculopathy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Duragesic 25 MCG #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system) Page(s): 68.

**Decision rationale:** According to MTUS guidelines, Duragesic (fentanyl transdermal system). Not recommended 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. It is manufactured by [REDACTED] and marketed by [REDACTED] (both subsidiaries of [REDACTED]). 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. In this case, the patient continued to have pain despite the use of high dose of opioids. There is no documentation of continuous monitoring of adverse reactions and of patient's compliance with her medication. In addition, there is no documentation that the patient developed tolerance to opioids or need continuous around the clock opioid administration. Therefore, the prescription of Duragesic 25mcg is not medically necessary.

**Percocet 75/325 MG #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): 76-79.

**Decision rationale:** According to MTUS guidelines, ongoing use of opioids should follow specific rules:(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status,appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: 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 monitoring of these outcomes over time should affect therapeutic decisions and provide a framework.The patient has been using opioids without

recent documentation of full control of pain and without any documentation of functional or quality of life improvement. There is no clear documentation of patient improvement in level of function, quality of life, adequate follow up for absence of side effects and aberrant behavior with a previous use of narcotics. There is no justification for the use of several narcotics. Therefore the prescription of Percocet 7.5/325mg #120 is not medically necessary.

**Ambien 10 MG #15:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists  
(<http://worklossdatainstitute.verioiponly.com/odgtwc/pain.htm>)

**Decision rationale:** According to ODG guidelines, Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists): First-line medications for insomnia. This class of medications includes zolpidem (Ambien and Ambien CR), zaleplon (Sonata), and eszopicolone (Lunesta). Benzodiazepine-receptor agonists work by selectively binding to type-1 benzodiazepine receptors in the CNS. All of the benzodiazepine-receptor agonists are schedule IV controlled substances, which means they have potential for abuse and dependency. Ambien is not recommended for long-term use to treat sleep problems. Furthermore, there is no documentation of the use of non pharmacologic treatment for the patient's sleep issue. There is no documentation and characterization of recent sleep issues with the patient. Therefore, the prescription of Ambien 10mg #15 is not medically necessary.