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| Case Number: | CM15-0136085 | | |
| Date Assigned: | 07/24/2015 | Date of Injury: | 07/09/1997 |
| Decision Date: | 10/19/2015 | UR Denial Date: | 06/16/2015 |
| Priority: | Standard | Application Received: | 07/14/2015 |

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: California, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 66 year old male who sustained an industrial injury on 7-9-97. In a progress note dated 4-16-15, the treating physician reports the injured worker "has been experiencing much more pain because his medications have been decreased over the past month" and that "he has not been receiving the shots for his back." It is noted the injured worker has been spending most of his time in bed and finds very little enjoyment in anything. Also noted are occasional nightmares, "non-existent" appetite, poor concentration, "thoughts of suicide-yes, no intent currently." "The physician notes that as a result of his increased pain, he is experiencing significant depression." Previous medication noted is Escitalopram, Fluoxetine, Paroxetine, Sertraline, Venlafaxine, Risperidone, Mirtazapine, and Lorazepam. It is noted that his primary problems currently relate to significant pain issues and the adjustment of his pain medications over the past few weeks and he notes his pain is fairly significant and as a result, his depression is worse. "This has been the same pattern observed consistently over the past 10 years" It is noted he attends his grandchildren's sporting events but this leads to huge issues related to his pain. In a progress note dated 5-14-15, the physician notes a chief complaint of "increased pain" since his last visit and that he has been putting on 2 Fentanyl 12mcg patches. He reports he has been using the Nucynta and is not having pain relief, but it is helpful for breakthrough pain but is not getting pain relief on a continuous basis and that the epidural did not work as well either. Straight leg raise is positive on the left and he has limited range of motion at the waist. He favors the left leg when walking and has tingling-dysthesia in the left leg, L5-S1 distribution per previous history. Reflexes are decreased at the Patella and Achilles. The CSPMP (controlled

substances prescription monitoring program) was reviewed and is reported as consistent with expectations. The plan is noted as Fentanyl 25mcg patch every 48 hours for 2 months and Nucynta 50mg and reassess pain level and activity level on the next visit, work on weaning the Fentanyl, and he will be seen in 2 months. It is noted that "he is still 10 Morphine mg equivalent above recommendations and would like him to be lower if not off entirely." He continues on Cymbalta, AcipHex, Lidoderm patches, Diclofenac, Tegaderm film to keep Lidoderm patches on, he is also using; Senokot, Bupropion, Lamotrigine, Clonazepam, Glyburide, Cyclo-benzaprine, noted that the worker thinks he might have discontinued this; Terazosin, Finasteride, Amlodipine, and Benadryl. The impression per visit dated 5-14-15 is noted as lumbar postlaminectomy syndrome, lumbar radicular low back pain, radiculopathy, lumbar degenerative disk disease, history of depression, narcotic dependency, and obesity. The requested treatment of Clonazepam 2mg #60, Hydromorphone 2mg #30, and Diazepam 5mg #21 was non-certified on 6-16-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Clonazepam 2 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p 24 regarding benzodiazepines, "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. The documentation submitted for review indicates that the injured worker has been using this medication since at least 3/2015. As the treatment is not recommended for long term use, the request is not medically necessary.

Hydromorphone 2 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p78 regarding ongoing management of opioids "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 nonadherent) drug related behaviors. These domains have been summarized as the 4 A's (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors). 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." Review of the available medical records reveals no documentation to support the medical necessity of hydromorphone nor any documentation addressing the '4 A's' domains, which is a recommended practice for the on-going management of opioids. Specifically, the notes do not appropriately review and document pain relief, functional status improvement, appropriate medication use, or side effects. The MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. Efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. It was noted per the medical records that UDS was performed 3/19/15 which was consistent with prescribed medications. As MTUS recommends to discontinue opioids if there is no overall improvement in function, medical necessity cannot be affirmed. The request is not medically necessary.

Diazepam 5 mg #21: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p24 regarding benzodiazepines, "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. The documentation submitted for review indicates that the injured worker has been using benzodiazepines including lorazepam and clonazepam long term since at least 3/2015. As the treatment is not recommended for long term use, the request is not medically necessary.