

<b>Case Number:</b>	CM15-0145771		
<b>Date Assigned:</b>	08/06/2015	<b>Date of Injury:</b>	05/22/1998
<b>Decision Date:</b>	09/03/2015	<b>UR Denial Date:</b>	07/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/27/2015

### 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: Arizona, California  
 Certification(s)/Specialty: Family Practice

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 64 year old woman sustained an industrial injury on 5-22-1998. The mechanism of injury is not detailed. Diagnoses include abdominal pain, nausea with vomiting, lumbar post-laminectomy syndrome, and reflex sympathetic dystrophy of the lower limb. Treatment has included oral and topical medications. Physician notes on a PR-2 dated 7-1-2015 show complaints of low back pain with radiation to the bilateral lower extremities rated 6 out of 10 and epigastric pain associated with nausea and vomiting. Recommendations include Duragesic patch, Percocet, Klonopin, Flector patch, DLC cream, Flexeril, Neurontin, Promethazine, Nexium, gastroenterology consultation, and follow up in three weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Diazepam 2mg #120 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 23.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Page(s): 24.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, Benzodiazepines are not recommended for long-term use because its efficacy is unproven and there is a risk of addiction. Most guidelines limit its use to 4 weeks and its range of action includes: sedation, anxiolytic, anticonvulsant, and muscle relaxant. The claimant had been on other muscle relaxants including Flexeril and Klonopin (Benzodiazepine) for several months. The claimant had been on these medications with high dose opioids increasing the risk of addiction. Valium is a long-acting Benzodiazepine and continued and chronic use with 1 refill is not medically necessary.

**Fentanyl 25mcg/hr #10 with 1 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system) Page(s): 44, 47.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl Page(s): 47.

**Decision rationale:** According to the guidelines, Fentanyl is an opioid analgesic with a potency eighty times that of morphine. Fentanyl is not recommended as a first-line therapy. The FDA-approved product labeling states that Fentanyl 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 claimant had been on Oxycodone for several months along with the Fentanyl. There was no indication for combining multiple opioids and no one opioid is superior to another. Weaning or Tricyclic failure was not noted. The pain was chronic for 10 years without recent mention of reduction in pain scores of current Fentanyl use. Continued use of Fentanyl is not medically necessary.

**Oxycodone/Acetaminophen 10/325mg #30 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 82-92.

**Decision rationale:** Oxycodone is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Oxycodone for several months in combination with Fentanyl. Without documentation improvement in pain or function over the past 10 years since the injury. There was no mention of Tylenol, NSAID, Tricyclic or weaning failure. The continued use of Oxycodone is not medically necessary.