

<b>Case Number:</b>	CM15-0183027		
<b>Date Assigned:</b>	09/23/2015	<b>Date of Injury:</b>	08/25/1999
<b>Decision Date:</b>	10/29/2015	<b>UR Denial Date:</b>	09/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2015

### 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: North Carolina

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 22 year old woman sustained an industrial injury on 8-25-1999. Diagnoses include complex regional pain syndrome of the right lower extremity. Treatment has included oral medications. Physician notes dated 8-26-2015 show complaints of chronic right knee pain with intermittent radiation to the right foot rated 7-8 out of 10 as well as symptoms of anxiety and depression and difficulty sleeping. The worker states the pain is significantly decreased with Oxycodone and her sleep is improved with Elavil. The physical examination shows anxiety, moderate discomfort, antalgic gait without the use of her cane, allodynia of the right knee with mild edema, mottling of the right lower extremity, limited flexion, right leg weakness and giving way secondary to pain, and intact skin integrity. Recommendations include Roxicodone, Oxycodone, Elavil, Xanax, Calmare treatment (out of pocket), urine drug screen, and follow up in three months.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Roxicodone 20mg #90:** 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 for chronic pain.

**Decision rationale:** The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (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 for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids: (a) If the patient has returned to work (b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox- AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there is documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function or activity specifically due to the medication. Therefore, all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.

**Elavil 100mg:** 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): Antidepressants for chronic pain.

**Decision rationale:** The California MTUS section on the requested medications states: Amitriptyline: Neuropathic pain: The starting dose may be as low as 10-25 mg at night, with increases of 10-25 mg once or twice a week up to 100 mg/day. (ICSI, 2007) The lowest effective dose should be used. (Dworkin, 2007) Fibromyalgia: One review recommended the following dosing regimen: Start with low doses, such as 5-10 mg 1-3 hours before bedtime. Dose may be increased by 5 mg at two-week intervals; final dose is dependent upon efficacy and patient tolerability to side effects. Doses that have been studied range from 25 to 50 mg at bedtime. (Goldenberg, 2007) The requested medication is a first line recommended agent for neuropathic pain treatment. However, no quantity is specified and therefore compliance with dosing recommendations cannot be verified. Therefore, the request is not medically necessary.

**Xanax 0.5mg:** 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:** The California chronic pain medical treatment guidelines section on benzodiazepines states: 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. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005) The chronic long-term use of this class of medication is recommended in very few conditions per the California MTUS. There is no evidence however of all failure of first line agents for the treatment of anxiety or Insomnia in the provided documentation. For this reason, the request is not medically necessary.