MAXIMUS Federal Services

Case Number:	CM15-0203371		
Date Assigned:	10/20/2015	Date of Injury:	03/26/2008
Decision Date:	12/29/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	10/15/2015

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 York
Certification(s)/Specialty: Internal 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 64 year old male who sustained an industrial injury on 3-26-08. A review of the medical records indicates he is undergoing treatment for lumbar disc herniation with left lower extremity radiculopathy, right femoral neck fracture - status post open reduction internal fixation on 3-27-08, right knee internal derangement, right shoulder rotator cuff tear - status post arthroscopic surgery November 2008, adhesive capsulitis right shoulder - status post arthroscopic surgery August 2009, status post ALIF L3-4 with decompression of the left peroneal nerve on 9-9-11, status post L1-2, L2-3, L3-4, L4-5, and L5-S1 PLIF 6-27-12, lumbar spinal cord stimulator implant 8-8-13, medication-induced gastritis, atrial fibrillation, hypertension, gastroesophageal reflux disease, hyperlipidemia, positive HIV, sleep disorder, and constipation. Medical records (5-15-15, 6-12-15, 7-13-15, 8-14-15, and 9-14-15) indicate ongoing complaints of low back pain with radicular symptoms of both lower extremities, affecting the left greater than right. He also complains of bilateral knee pain, which is noted to be non-industrial. He rates his pain "5-8 out of 10". The physical exam (9-14-15) reveals tenderness to palpation of the "posterior lumbar musculature with increased muscle rigidity". Decreased lumbar range of motion is noted with "obvious muscle guarding". Motor testing is "4 to 4+ out of 5" on the left side. Deep tendon reflexes are noted to be "2 out of 4" on the right and "1 out of 4" on the left. The sensory exam is noted to be decreased along the lateral thigh and lateral calf in the L5-S1 distribution in the left. The straight leg raise is positive in bilateral lower extremities at 60 degrees. Diagnostic studies have included an MRI of the lumbar spine, a CT scan of the lumbar spine, and EMG-NCV studies of bilateral lower extremities. Treatment has included a home exercise program, a steroid

injection in the left knee, trigger point injections, a spinal cord stimulator, and medications. His medications include Duragesic, Neurontin, Percocet, Flexeril, Restoril, Tribayka, and Truvada. He has been receiving Duragesic, Neurontin, Percocet, Flexeril, and Restoril since, at least, 5-15-15. The utilization review (9-22-15) includes requests for authorization of Duragesic 75mcg #15, Percocet 10-325mg #90, Neurontin 600mg, Flexeril 10mg, and Restoril 30mg. All requests were denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duragesic 75mcg 15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Duragesic (fentanyl transdermal system).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Opioids.

Decision rationale: According to ODG and MTUS, Fentanyl is a long-acting narcotic analgesic used to manage both acute and chronic pain. Fentanyl is an opioid analgesic with a potency of eighty times that of Morphine. Fentanyl transdermal (Duragesic) patches are indicated for the management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. Duragesic patches should only be used in patients who are currently on opioid therapy for which tolerance has developed. Patches are worn for a 72-hour period. In this case, the treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no compelling evidence presented by the treating provider that indicates this injured worker, had any significant improvements from use of this medication, and also review of Medical Records do not indicate that in this injured worker, previous use of this medication has been effective in maintaining any measurable objective evidence of functional improvement. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested treatment: Duragesic 75mcg 15 is not medically necessary.
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Percocet 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Weaning of Medications.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Opioids.

Decision rationale: The California MTUS chronic pain medical treatment guidelines recommend specific guidelines for the ongoing use of narcotic pain medication to treat chronic pain. "Recommendations include the lowest possible dose be used as well as ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects. It is also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the use of the medication." The CA MTUS Guidelines define functional improvement as "a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management and a reduction in the dependency on continued medical treatment." Therapies should be focused on functional restoration rather than the elimination of pain. The medical records submitted for review does not include the above recommended documentation. There were no functional improvements noted with the use of the medication. There is no change in medical dependence. Therefore the requested treatment: Percocet 10/325mg #90 is not medically necessary.

Neurontin 600mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Anti-epilepsy drugs (AEDs) for pain.

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. Neurontin has been part of his medical regimen. However In this case, there is no compelling evidence presented by the treating provider that indicates this injured worker has had any significant improvements from this medication, and also review of Medical Records do not clarify that previous use of this medication has been effective in this injured worker for maintaining the functional improvement. Medical necessity for Neurontin has not been established.

Flexeril 10mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Muscle relaxants.

Decision rationale: According to the reviewed literature, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect

in the first four days of treatment. In addition, this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. In this case, the available records are not clear if this injured worker has any functional improvement from prior Cyclobenzaprine use. Based on the currently available information and per review of guidelines, the medical necessity for this muscle relaxant medication has not been established. The requested treatment: Flexeril 10mg is not medically necessary and appropriate.

Restoril 30mg: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Benzodiazepines.

Decision rationale: Restoril (Temazepam) is an intermediate-acting 3-hydroxy hypnotic of the benzodiazepine class of psychoactive drugs. It is approved for the short-term treatment of insomnia. According to CA MTUS Guidelines, benzodiazepines are prescribed for anxiety. They are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. There is no documentation provided indicating that the patient has a diagnosis of insomnia or indicating the duration of therapy with this medication. There are no guideline criteria that support the long-term use of benzodiazepines for sleep disturbances. Medical necessity for the requested medication has not been established. The requested treatment: Restoril 30mg is not medically necessary.