

Case Number:	CM14-0165549		
Date Assigned:	10/10/2014	Date of Injury:	12/10/2009
Decision Date:	11/12/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/07/2014

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. The expert reviewer is Board Certified in Preventive Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

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

According to the records made available for review, this is a 46-year-old female with a 12/10/09 date of injury,. At the time (9/17/14) of request for authorization for retrospective request for Sonata 5 mg # 45, prescribed on 9/17/14, retrospective request for Fentanyl 25 mcg/hr # 10 prescribed on 9/17/14, retrospective request for Fentanyl 12mcg/hr # 10, prescribed on 9/17/14, retrospective request for Chlordiazepoxide HCL 10 mg # 30, prescribed on 9/17/14, and retrospective request for Percocet 10-325 mg # 125, prescribed on 9/17/14, there is documentation of subjective (bilateral low back and right hand pain) and objective (ambulates with steady gate without a cane) findings, current diagnoses (reflex sympathetic dystrophy (arm), pain in joint (hand), chronic insomnia, and pain in joint (forearm)), and treatment to date (medications (including ongoing treatment with Sonata, Fentanyl, Percocet, and Chlordiazepoxide since at least 2/19/14) and home exercise program). Regarding Sonata, there is no documentation of short-term (up to 5 weeks) treatment; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Sonata use to date. Regarding Fentanyl patch, there is no documentation of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient is already receiving opioid therapy, has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Fentanyl 25 mcg/h; and no contraindications exist; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Fentanyl patch use to date. Regarding Chlordiazepoxide, there is no documentation of short-term (up to 4 weeks) treatment; functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a

result of Chlordiazepoxide use to date. Regarding Percocet, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Percocet use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Sonata 5 mg # 45, prescribed on 9/17/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia Treatment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental illness & Stress, Insomnia treatment Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS does not address this issue. ODG identifies Zaleplon (Sonata) as a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (up to 5 weeks) treatment of insomnia. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of reflex sympathetic dystrophy (arm), pain in joint (hand), chronic insomnia, and pain in joint (forearm). However, given documentation of ongoing treatment with Sonata since at least 2/19/14, there is no documentation of short-term (up to 5 weeks) treatment; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Sonata use to date. Therefore, based on guidelines and a review of the evidence, the request for retrospective request for Sonata 5 mg # 45, prescribed on 9/17/14 is not medically necessary.

Retrospective request for Fentanyl 25 mcg/hr # 10 prescribed on 9/17/14: 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): 44. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Duragesic and Fentanyl Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20; and FDA

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means, as criteria necessary to support the medical necessity of Fentanyl. MTUS Chronic Pain Medical Treatment Guidelines identifies that Fentanyl is not recommended as first-line therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation that Fentanyl is not for use in routine musculoskeletal pain. FDA identifies documentation of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient is already receiving opioid therapy, has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Fentanyl 25 mcg/h; and no contraindications exist, as criteria necessary to support the medical necessity of Fentanyl patch. Within the medical information available for review, there is documentation of diagnoses of reflex sympathetic dystrophy (arm), pain in joint (hand), chronic insomnia, and pain in joint (forearm). In addition, there is documentation of pain and ongoing treatment with Fentanyl patch. However, despite documentation of pain, there is no documentation of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient is already receiving opioid therapy, has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Fentanyl 25 mcg/h; and no contraindications exist. In addition, given documentation of ongoing treatment with Fentanyl patch, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Fentanyl patch use to date. Therefore, based on guidelines and a review of the evidence, the request for retrospective request for Fentanyl 25 mcg/hr # 10 prescribed on 9/17/14 is not medically necessary.

Retrospective request for Fentanyl 12mcg/hr # 10, prescribed on 9/17/14: 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): 44. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Duragesic and Fentanyl Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20; and FDA

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means, as criteria necessary to support the medical necessity of Fentanyl. MTUS Chronic Pain Medical Treatment Guidelines identifies that Fentanyl is not recommended as first-line therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation that Fentanyl is not for use in routine musculoskeletal pain. FDA identifies documentation of persistent, moderate to severe chronic

pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient is already receiving opioid therapy, has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Fentanyl 25 mcg/h; and no contraindications exist, as criteria necessary to support the medical necessity of Fentanyl patch. Within the medical information available for review, there is documentation of diagnoses of reflex sympathetic dystrophy (arm), pain in joint (hand), chronic insomnia, and pain in joint (forearm). In addition, there is documentation of pain and ongoing treatment with Fentanyl patch. However, despite documentation of pain, there is no documentation of persistent, moderate to severe chronic pain that requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; that the patient is already receiving opioid therapy, has demonstrated opioid tolerance, and requires a total daily dose at least equivalent to Fentanyl 25 mcg/h; and no contraindications exist. In addition, given documentation of ongoing treatment with Fentanyl patch, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Fentanyl patch use to date. Therefore, based on guidelines and a review of the evidence, the request for retrospective request for Fentanyl 12mcg/hr # 10, prescribed on 9/17/14 is not medically necessary.

Retrospective request for Chlordiazepoxide HCL 10 mg # 30, prescribed on 9/17/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that benzodiazepines are not recommended for long-term and that most guidelines limit use to 4 weeks. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of reflex sympathetic dystrophy (arm), pain in joint (hand), chronic insomnia, and pain in joint (forearm). However, given documentation of records reflecting ongoing treatment with Chlordiazepoxide since at least 2/19/14, there is no documentation of short-term (up to 4 weeks) treatment; functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Chlordiazepoxide use to date. Therefore, based on guidelines and a review of the evidence, the request for retrospective request for Chlordiazepoxide HCL 10 mg # 30, prescribed on 9/17/14 is not medically necessary.

Retrospective request for Percocet 10-325 mg # 125, prescribed on 9/17/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of reflex sympathetic dystrophy (arm), pain in joint (hand), chronic insomnia, and pain in joint (forearm). However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given documentation of records reflecting ongoing treatment with Percocet since at least 2/19/14, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Percocet use to date. Therefore, based on guidelines and a review of the evidence, the request for retrospective request for Percocet 10-325 mg # 125, prescribed on 9/17/14 is not medically necessary.