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| <b>Case Number:</b>   | CM14-0191989 |                              |            |
| <b>Date Assigned:</b> | 12/01/2014   | <b>Date of Injury:</b>       | 08/09/1999 |
| <b>Decision Date:</b> | 01/13/2015   | <b>UR Denial Date:</b>       | 10/29/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/17/2014 |

### 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 Anesthesiology, has a subspecialty in Pain Management 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 57-year-old male with an 8/9/99 date of injury. At the time (10/6/14) of request for authorization for Lunesta 3mg #30 with 2 refills, Temazepam 30mg #30 with 2 refills, Oxycontin 40mg #120 with 2 refills, Methadone 10mg #180 with 2 refills, Methadone 10mg #180 with 2 refills, Norco 10/325mg #120 with 2 refills, Norco 10/325mg #120 with 2 refills, Amrix 15mg #60 with 2 refills, and Amrix 15mg #60 with 2 refills, there is documentation of subjective (increased severe back pain) and objective (tenderness over the spinal stimulator area and limited motor strength testing due to pain) findings, current diagnoses (chronic pain syndrome and reflex sympathetic dystrophy), and treatment to date (medications (including ongoing treatment with Lunesta, Oxycontin, Norco, Temazepam, Amrix, and Methadone). Medical reports identify that the patient has insomnia; that medications provide functional benefit; and there is ongoing opioid treatment assessment. Regarding Lunesta 3mg #30, there is no documentation of short-term (up to 35 days) 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 specific result of Lunesta use to date. Regarding Temazepam 30mg #30, there is no documentation of short-term (up to 4 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 specific result of Temazepam use to date. Regarding Oxycontin 40 mg #120, Methadone 10mg #180, and Norco 10/325mg #120, 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 specific result of Oxycontin, Methadone, and Norco use to date. Regarding Amrix 15mg #60, there is no documentation of short-term (less than two 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 specific result of Amrix use to date.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Lunesta 3mg #30 with 2 refills:** 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)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, 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 states non-benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists) are first-line medications for insomnia which includes eszopicolone (Lunesta). In addition, ODG identifies that Lunesta is the only benzodiazepine-receptor agonist FDA approved for use longer than 35 days. 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 chronic pain syndrome and reflex sympathetic dystrophy. In addition, there is documentation of insomnia. However, given documentation of ongoing treatment with Lunesta, there is no documentation of short-term (up to 35 days) treatment. In addition, despite documentation that medications provide functional benefit, 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 specific result of Lunesta use to date. Therefore, based on guidelines and a review of the evidence, the request for Lunesta 3mg #30 with 2 refills is not medically necessary.

**Temazepam 30mg #30 with 2 refills:** 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 chronic pain syndrome and reflex sympathetic dystrophy. However, given documentation of ongoing treatment with Temazepam, there is no documentation of short-term (up to 4 weeks) treatment. In addition, despite documentation that medications provide functional benefit, 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 specific result of Temazepam use to date. Therefore, based on guidelines and a review of the evidence, the request for Temazepam 30mg #30 with 2 refills is not medically necessary.

**Oxycontin 40mg #120 with 2 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Oxycodone Page(s): 74-80; 92. 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 documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time, as criteria necessary to support the medical necessity of Oxycontin. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies 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 Oxycontin. 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 chronic pain syndrome and reflex sympathetic dystrophy. In addition, given a diagnosis of reflex sympathetic dystrophy, there is documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. Furthermore, given documentation that there is ongoing opioid treatment assessment, there is 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. However, despite documentation that medications provide functional benefit, 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 specific result of Oxycontin use to date. Therefore, based on guidelines and a review of the evidence, the request for Oxycontin 40mg #120 with 2 refills is not medically necessary.

**Methadone 10mg #180 with 2 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Methadone; Opioids Page(s): 61-62; 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 identifies documentation of Methadone used as a second-line drug for moderate to severe pain if the potential benefit outweighs the risk, and that Methadone is being prescribed by providers with experience in using it, as criteria necessary to support the medical necessity of Methadone. In addition, 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 chronic pain syndrome and reflex sympathetic dystrophy. In addition, given documentation of ongoing treatment with opioids, there is documentation of Methadone used as a second-line drug for moderate to severe pain. Furthermore, given documentation that there is ongoing opioid treatment assessment, there is 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. However, despite documentation that medications provide functional benefit, 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 specific result of Methadone use to date. Therefore, based on guidelines and a review of the evidence, the request for Methadone 10mg #120 is not medically necessary.

**Methadone 10mg #180 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Methadone; Opioids Page(s): 61-62; 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 identifies documentation of Methadone used as a second-line drug for moderate to severe pain if the potential benefit outweighs the risk, and that Methadone is being prescribed by providers with experience in using it, as criteria necessary to support the medical necessity of Methadone. In

addition, 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 chronic pain syndrome and reflex sympathetic dystrophy. In addition, given documentation of ongoing treatment with opioids, there is documentation of Methadone used as a second-line drug for moderate to severe pain. , given documentation that there is ongoing opioid treatment assessment, there is 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. However, despite documentation that medications provide functional benefit, 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 specific result of Methadone use to date. Therefore, based on guidelines and a review of the evidence, the request for Methadone 10mg #120 is not medically necessary.

**Norco 10/325mg #120 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 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 chronic pain syndrome and reflex sympathetic dystrophy. In addition, given documentation that there is ongoing opioid treatment assessment, there is 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. However, despite documentation that medications provide functional benefit, 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 specific result of Norco use to date.

Therefore, based on guidelines and a review of the evidence, the request for Norco 10/325mg #120 with 2 refills is not medically necessary.

**Norco 10/325mg #120 with 2 refills: Upheld**

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

**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 chronic pain syndrome and reflex sympathetic dystrophy. In addition, given documentation that there is ongoing opioid treatment assessment, there is 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. However, despite documentation that medications provide functional benefit, 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 specific result of Norco use to date. Therefore, based on guidelines and a review of the evidence, the request for Norco 10/325mg #120 with 2 refills is not medically necessary.

**Amrix 15mg #60 with 2 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20<Insert Other Basis/Criteria>

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle relaxant. ODG identifies that muscle relaxants are recommended for short-term (less than two

weeks) treatment. 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 chronic pain syndrome and reflex sympathetic dystrophy. In addition, given documentation of ongoing treatment with opioids, there is documentation of Amrix used as a second line agent. However, despite documentation of spasms, and given documentation of an 8/9/99 date of injury, there is no documentation of acute muscles spasms or acute exacerbation of chronic low back pain. In addition, given documentation of ongoing treatment with Amrix, there is no documentation of short-term (less than two weeks) treatment. Furthermore, despite documentation that medications provide functional benefit, 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 specific result of Amrix use to date. Therefore, based on guidelines and a review of the evidence, the request for Amrix 15mg #60 with 2 refills is not medically necessary.

**Amrix 15mg #60 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain) 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 documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle relaxant. ODG identifies that muscle relaxants are recommended for short-term (less than two weeks) treatment. 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 chronic pain syndrome and reflex sympathetic dystrophy. In addition, given documentation of ongoing treatment with opioids, there is documentation of Amrix used as a second line agent. However, despite documentation of spasms, and given documentation of an 8/9/99 date of injury, there is no documentation of acute muscles spasms or acute exacerbation of chronic low back pain. In addition, given documentation of ongoing treatment with Amrix, there is no documentation of short-term (less than two weeks) treatment. Furthermore, despite documentation that medications provide functional benefit, 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 specific result of Amrix use to date. Therefore, based on guidelines and a review of the evidence, the request for Amrix 15mg #60 with 2 refills is not medically necessary.