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| <b>Case Number:</b>   | CM14-0084794 |                              |            |
| <b>Date Assigned:</b> | 08/08/2014   | <b>Date of Injury:</b>       | 05/03/2001 |
| <b>Decision Date:</b> | 06/03/2015   | <b>UR Denial Date:</b>       | 05/28/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/06/2014 |

### 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. 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: Pennsylvania  
 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 57 year old female who sustained an industrial injury on 5/3/01. She reported left sided neck and infrascapular injury. The injured worker was diagnosed as having degeneration of cervical intervertebral disc, displacement of cervical intervertebral disc without myelopathy, chronic pain syndrome, possible thoracic outlet syndrome, lumbar post-laminectomy syndrome, degeneration of lumbar or lumbosacral intervertebral disc, thoracic or lumbosacral neuritis or radiculitis, lumbar facet joint pain, cervical facet joint pain, brachial neuritis, chronic depression, anxiety state, and malignant neoplasm soft tissues of cervical spine. Treatment to date has included cervical fusion, neck collar, oral medications including Norco, topical medications including Fentanyl patch, physical therapy and home exercise program. Pain was rated as 5/10 in severity most of the time in 2013. Work status in August 2013 was noted as permanent and stationary, unable to work. Gabpaentin, vicodin, and clonzaepam were prescribed in 2002. Medications in 2010 included norco, gabapentin, fentanyl, and clonazepam; these medications were continued through 2013 and 2014. Clonazepam was noted to be prescribed for spasms, anxiety, and sleep. Cervical fusion and removal of schwannoma was performed in May 2014. At a visit on 5/16/14, the injured worker complains of neck pain and bilateral arm pain. The injured worker states her neck pain is improved but sore following cervical fusion. She reported very severe interference with most daily activities. The injured worker states her pain is 7-10/10 in severity and without medications she would be completely incapacitated. Physical exam showed severe tenderness to palpation over intrascapular area and spinal musculature from C7-T9, moderate tenderness to palpation from C3-C7 and over bilateral trapezii and bilateral

upper arms, severe tenderness to palpation on medial borders of bilateral scapula on exam of thoracic spine and moderate diffuse tenderness to palpation over lumbar paraspinal musculature and bilateral sacroiliac (SI) joints. Similar symptoms and findings were reported at a visit on 5/21/14. Medications were noted to reduce pain and increase activity tolerance, but specific changes in activities of daily living were not described, and the documentation also states that the injured worker reported very severe interference and prevention of most daily activities with inability to provide some aspects of self care. Prescriptions were given for Fentanyl patch, Clonazepam, Norco, Bupropion XL and Gabapentin and requests were made for home health aide, physical therapy, occupational therapy and follow up appointment. On 5/29/14, Utilization Review (UR) non-certified or modified requests for the medications currently under Independent Medical Review, citing the MTUS.

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

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

#### **Fentanyl Patch 50 mcg #10: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines duragesic (fentanyl transdermal system) p. 44, opioids p. 74-96.

**Decision rationale:** This injured worker has chronic neck and back pain. Duragesic patch has been prescribed for several years, since 2010. Duragesic (transdermal fentanyl) is a potent opioid which is not recommended as a first-line therapy. The FDA product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. None of these aspects of prescribing are in evidence. Work status was noted as permanent and stationary/unable to work. There was no discussion of functional goals or opioid contract. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, mechanical and compressive etiologies, and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. The prescribing physician does not specifically address function with respect to prescribing opioids. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Although the provider noted that medications were noted to reduce pain, pain severity rating was unimproved. Change in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. Activities were noted to be limited. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of

abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. As currently prescribed, Fentanyl patch does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

**Norco 10/325 mg #180 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

**Decision rationale:** This injured worker has chronic back and neck pain. Opioids have been prescribed for many years, with documentation indicating norco has been prescribed since at least 2010. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. None of these aspects of prescribing are in evidence. Work status was noted as permanent and stationary/unable to work. There was no discussion of functional goals or opioid contract. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, mechanical and compressive etiologies, and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. The prescribing physician does not specifically address function with respect to prescribing opioids. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Although the provider noted that medications were noted to reduce pain, pain severity rating was unimproved. Change in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. Activities were noted to be limited. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. As currently prescribed, norco does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

**Gabapentin 300 mg #240 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines anticonvulsants Page(s): 16-22.

**Decision rationale:** Per the MTUS, anti-epilepsy drugs (AEDs) are recommended for neuropathic pain due to nerve damage. Gabapentin has been shown to be effective for treatment of diabetic neuropathy and postherpetic neuralgia and has been considered a first line treatment for neuropathic pain. A good response to the use of AEDs is defined as a 50% reduction in pain and a moderate response as a 30% reduction. Lack of at least a 30% response per the MTUS would warrant a switch to a different first line agent or combination therapy. After initiation of treatment, there should be documentation of pain relief with improvement in function, and documentation of any side effects, with continued use of AEDs dependent on improved outcomes versus tolerability of adverse effects. This injured worker has chronic back and neck pain. Gabapentin has been prescribed for many years, without documentation of improvement in pain or function. Pain severity scores have not improved, activities of daily living remain limited, and the injured worker was noted to be unable to work. Due to lack of documentation of at least a moderate response to gabapentin, and lack of functional improvement, the request for gabapentin is not medically necessary.

**Clonazepam 1 mg #90 with 3 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepines p. 24, muscle relaxants p. 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: benzodiazepines.

**Decision rationale:** Per the MTUS, benzodiazepines are 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. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long term use may actually increase anxiety. The MTUS states that a more appropriate treatment for anxiety disorder is an antidepressant. The MTUS does not recommend benzodiazepines for long term use for any condition. The MTUS does not recommend benzodiazepines as muscle relaxants. The Official Disability Guidelines recommend against prescribing benzodiazepines with opioids and other sedatives. This injured worker has chronic back and neck pain, muscle spasms, and anxiety. Clonazepam has been prescribed for many years, possibly for more than 10 years, and was noted to be used for spasms, anxiety, and sleep. There was documentation of concomitant use of opioids. There was no documentation of functional improvement as a result of use of clonazepam. There was ongoing documentation of limitations in activities of daily living and inability to work, without decrease in medication use or decrease in dependence on medical care. Due to length of use significantly in excess of the guidelines and lack of functional improvement, the request for clonazepam is not medically necessary.

**Fentanyl patch 75 mcg #10:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines duragesic (fentanyl transdermal system) p. 44, opioids p. 74-96.

**Decision rationale:** This injured worker has chronic neck and back pain. Duragesic patch has been prescribed for several years, since 2010. Duragesic (transdermal fentanyl) is a potent opioid which is not recommended as a first-line therapy. The FDA product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. None of these aspects of prescribing are in evidence. Work status was noted as permanent and stationary/unable to work. There was no discussion of functional goals or opioid contract. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, mechanical and compressive etiologies, and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. The prescribing physician does not specifically address function with respect to prescribing opioids. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Although the provider noted that medications were noted to reduce pain, pain severity rating was unimproved. Change in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. Activities were noted to be limited. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. As currently prescribed, fentanyl patch does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

**Clonazepam 1 mg #105:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepines p. 24, muscle relaxants p. 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: benzodiazepines.

**Decision rationale:** Per the MTUS, benzodiazepines are 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. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long term use may actually increase anxiety. The MTUS states that a more appropriate treatment for anxiety disorder is an antidepressant. The MTUS does not recommend benzodiazepines for long term use for any condition. The MTUS does not

recommend benzodiazepines as muscle relaxants. The Official Disability Guidelines recommend against prescribing benzodiazepines with opioids and other sedatives. This injured worker has chronic back and neck pain, muscle spasms, and anxiety. Clonazepam has been prescribed for many years, possibly for more than 10 years, and was noted to be used for spasms, anxiety, and sleep. There was documentation of concomitant use of opioids. There was no documentation of functional improvement as a result of use of clonazepam. There was ongoing documentation of limitations in activities of daily living and inability to work, without decrease in medication use or decrease in dependence on medical care. Due to length of use significantly in excess of the guidelines and lack of functional improvement, the request for clonazepam is not medically necessary.

**Norco 10/325 mg #180: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

**Decision rationale:** This injured worker has chronic back and neck pain. Opioids have been prescribed for many years, with documentation indicating norco has been prescribed since at least 2010. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. None of these aspects of prescribing are in evidence. Work status was noted as permanent and stationary/unable to work. There was no discussion of functional goals or opioid contract. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, mechanical and compressive etiologies, and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. The prescribing physician does not specifically address function with respect to prescribing opioids. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient has failed a trial of non-opioid analgesics. Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Although the provider noted that medications were noted to reduce pain, pain severity rating was unimproved. Change in activities of daily living, discussion of adverse side effects, and screening for aberrant drug-taking behaviors were not documented. Activities were noted to be limited. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. As currently prescribed, norco does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

**Gabapentin 300 mg #240: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines anticonvulsants Page(s): 16-22.

**Decision rationale:** Per the MTUS, anti-epilepsy drugs (AEDs) are recommended for neuropathic pain due to nerve damage. Gabapentin has been shown to be effective for treatment of diabetic neuropathy and postherpetic neuralgia and has been considered a first line treatment for neuropathic pain. A good response to the use of AEDs is defined as a 50% reduction in pain and a moderate response as a 30% reduction. Lack of at least a 30% response per the MTUS would warrant a switch to a different first line agent or combination therapy. After initiation of treatment, there should be documentation of pain relief with improvement in function, and documentation of any side effects, with continued use of AEDs dependent on improved outcomes versus tolerability of adverse effects. This injured worker has chronic back and neck pain. Gabapentin has been prescribed for many years, without documentation of improvement in pain or function. Pain severity scores have not improved, activities of daily living remain limited, and the injured worker was noted to be unable to work. Due to lack of documentation of at least a moderate response to gabapentin, and lack of functional improvement, the request for gabapentin is not medically necessary.