

<b>Case Number:</b>	CM13-0057864		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	03/20/1999
<b>Decision Date:</b>	03/27/2014	<b>UR Denial Date:</b>	11/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Spine Surgery and is licensed to practice in Texas and 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 physician 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:

The patient is a 59-year-old male who sustained an unspecified injury on 03/20/1999. The patient was evaluated on 09/26/2013 for continued pain to the right shoulder. The patient rated his pain 6 on a scale of 1 to 10 and had complaints of poor sleep. Per the documentation submitted for review, the patient stated his medications were less effective and it was noted the patient had side effects of GI upset. The documentation submitted for review indicated the patient was participating in a home exercise program. It was further noted the patient underwent an MRI to the right shoulder on 10/03/2011 which had significant findings. The patient subsequently underwent a right shoulder arthroscopy with intra-articular debridement of the anterior and interior superior labrum as well as a partial thickness articular sided care of the rotator cuff, arthroscopic subacromial decompression on 03/21/2012. The patient's medication regimen was noted as Aciphex 20 mg tablets daily, Ambien 10 mg tablet at bedtime as needed, Colace 250 mg daily, Duragesic 100 mcg over an hour patch every 2 days, Ibuprofen 800 mg tablet 3 times a day as needed, Neurontin 800 mg tablet 4 times a day as needed, Wellbutrin 150 mg tablet daily, Lidoderm 5% patch 12 hours per day, Flexeril 10 mg 3 times a day as needed, MiraLax 1 teaspoon full in a glass of water once per day as needed for constipation, Duragesic 25 mcg over an hour patch every 2 days and Lortab 10/500 tablet every 4 to 6 hours as needed for pain. Per the documentation submitted for review, the patient's medications on 12/20/2012 were as follows: Aciphex 20 mg tablets daily, Ambien 10 mg tablet at bedtime as needed, Colace 250 mg daily, Duragesic 100 mcg over an hour patch every 2 days, ibuprofen 800 mg tablet 3 times a day as needed, Neurontin 800 mg tablet 4 times a day, Wellbutrin XL 150 mg tablet daily, Lidoderm 5% patch 12 hours per day, Flexeril 10 mg 3 times a day as needed, MiraLax 1 teaspoon full in a glass of water once per day as needed for constipation, Lortab 10/500 tablet every 4 to 6 hours as needed for pain, Duragesic 25 mcg over an hour patch every 2 days. Thus,

indicating the patient had been on the same medication regimen for a prolonged period of time. Upon re-evaluation on 10/24/2013, the evaluation noted the patient had no new problems or side effects. It was indicated the patient's side effects were being controlled by medication. The documentation submitted for review indicates the patient stated that his pain level had increased since his last visit. The patient additionally stated that his medications were working well. The evaluation dated 10/24/2013 did not have the patient's pain on the Visual Analog Scale.

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

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

**The request for Duragesic 100mcg, #15:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-Going Management.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Fentanyl transdermal and Opioid on-going management Page(s): 78 and 93.

**Decision rationale:** The request for Duragesic 100 mcg, #15 is non-certified. The patient was noted to have been on the medications for longer than 10 months. The California MTUS Guidelines recommend ongoing monitoring of 4 domains in the case of opioid usage. The 4 domains include: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant or nonadherent drug related behaviors. The documentation submitted for review indicated the patient's analgesic effect of the medication was decreasing with usage. Upon evaluation on 10/24/2013 the patient's pain level was not indicated on the examination. Furthermore, the patient complained that his pain had been increasing with treatment. California MTUS Guidelines recommend the discontinuation of opioids when there is no overall improvement in function unless there are extenuating circumstances. The documentation submitted for review did not indicate the patient had any extenuating circumstances to continue the medication. It is noted the treatment plan indicated the use of a Fentanyl transdermal patch is every 2 days; however, the California MTUS Guidelines recommend patches be worn for 72 hour period. Therefore, the dosage being provided to the patient exceeds guideline recommendations. Given the information submitted for review, the request for Duragesic 100 mcg, #15 is non-certified.

**The request for Zolpidem:** 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): Pain, Zolpidem (Ambien)

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

**Decision rationale:** The request for Zolpidem 10 mg #20 is non-certified. The documentation submitted for review indicated the patient had poor quality of sleep and that the patient had been on the medication since prior to 12/20/2012. Upon evaluation on 09/26/2013 the patient noted his quality of sleep as poor. Therefore, the continued use of the medication is not supported. Furthermore, the Official Disability Guidelines recommend the use of Zolpidem (Ambien) be short term, usually 2 to 6 weeks, for the treatment of insomnia. The patient was noted to have been taking the medication for longer than 10 months, therefore, far exceeding guideline recommendations. As the efficacy of the medication is unclear, the continued use is not supported. Given the information submitted for review, the request of Zolpidem 10 mg #20 is non-certified.