MAXIMUS Federal Services

Case Number:	CM14-0006244		
Date Assigned:	03/03/2014	Date of Injury:	03/25/2002
Decision Date:	09/17/2014	UR Denial Date:	12/23/2013
Priority:	Standard	Application Received:	01/16/2014

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 Family 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:

The injured worker is a 41 year old male patient who reported an industrial injury on 3/25/2002, over twelve (12) years ago, to the back attributed to the performance of his customary job tasks. The patient complains of persistent pain to the lower back radiating to the BLEs. The patient is prescribed opioids and hypnotics for the treatment of chronic low back pain. The patient is noted to be able to perform ADLs while taking medications; however cold weather has increased his pain. The patient undergoes random drug screens in the office. The patient is prescribed OxyContin 10mg; Oxycodone 5mg; Ambien 5mg; Neurontin 300mg; Naproxen; and Tizanidine 4mg. The objective findings on examination included TTP with spasms to the paralumbar muscles; reduced lumbar spine ROM; SLR positive bilaterally. The diagnosis was s/p artificial disc replacement L4-L5 and L5-S1; bilateral lower extremity radicular pain; sacrococcygeal pain; opioid dependence.

IMR ISSUES, DECISIONS AND RATIONALES

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

OXYCONTIN 10MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-306. Decision based on Non-MTUS Citation American College of Occupational

and Environmental Medicine (ACOEM), 2ndEdition, (2004) chapter 6 pages 114-116Official Disability Guidelines (ODG) pain chapter opioids.

Decision rationale: The prescription for OxyContin 10 mg #90 for short acting pain is being prescribed as an opioid analgesic for the treatment of chronic pain to the back for the date of injury 12 years ago. The objective findings on examination do not support the medical necessity for continued opioid analgesics status post artificial disc replacement to the lumbar spine. The patient is being prescribed opioids for mechanical back pain which is inconsistent with the recommendations of the CA MTUS. There is no objective evidence provided to support the continued prescription of opioid analgesics for the cited diagnoses and effects of the industrial claim. The patient should be titrated down and off the prescribed OxyContin 10mg #90. The patient is 12 years status post DOI with reported continued issues. There is no demonstrated medical necessity for the continuation of opioids for the effects of the industrial injury. The chronic use of OxyContin 10 mg #90 is not recommended by the CA MTUS; the ACOEM Guidelines or the Official Disability Guidelines for the long term treatment of chronic back pain. The prescription of opiates on a continued long term basis is inconsistent with the CA MTUS and the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain. The current prescription of opioid analgesics is inconsistent with evidence based guidelines. The prescription of opiates on a continued long-term basis is inconsistent with the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain issues. Evidence based guidelines necessitate documentation that the patient has signed an appropriate pain contract, functional expectations have been agreed to by the clinician and the patient, pain medications will be provided by one physician only, and the patient agrees to use only those medications recommended or agreed to by the clinician to support the medical necessity of treatment with opioids. The ACOEM Guidelines updated chapter on chronic pain states "Opiates for the treatment of mechanical and compressive etiologies: rarely beneficial. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues, such as, tolerance, opioid-induced hyperalgesia, long-range adverse effects such as hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect." ACOEM guidelines state that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal symptoms; they should be used only if needed for severe pain and only for a short time. The long-term use of opioid medications may be considered in the treatment of chronic musculoskeletal pain, if: The patient has signed an appropriate pain contract; Functional expectations have been agreed to by the clinician and the patient; Pain medications will be provided by one physician only; The patient agrees to use only those medications recommended or agreed to by the clinician. ACOEM also notes that "pain medications are typically not useful in the sub-acute and chronic phases and have been shown to

be the most important factor impeding recovery of function." There is no clinical documentation by with objective findings on examination to support the medical necessity of OxyContin 10mg for this long period of time or to support ongoing functional improvement. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with the prescribed OxyContin 10mg. There is no demonstrated medical necessity for the prescribed Opioids. Therefore, the continued prescription for OxyContin 10 mg #90 is not demonstrated to be medically necessary.

OXYCODONE 5MG #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-306,Chronic Pain Treatment Guidelines opioids Page(s): 74-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chapter on pain, opioids, criteria for useAmerican College of Occupational and Environmental Medicine (ACOEM), 2ndEdition, (2004) chapter 6 pages 114-16.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines section on Opioids, Ongoing Management recommends; "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects." The medical records provided for review do not contain the details regarding the above guideline recommendations. The opportunity for weaning was provided. There is no objective evidence provided to support the continued prescription of opioid analgesics for the cited diagnoses and effects of the industrial claim. There is no documented sustained functional improvement. There is no medical necessity for opioids directed to chronic mechanical neck and back pain. The prescription for Oxycodone 5mg is being prescribed as opioid analgesics for the treatment of chronic back pain against the recommendations of the ACOEM Guidelines. There is no objective evidence provided to support the continued prescription of opioid analgesics for chronic back pain 12 years after the initial DOI and subsequent to the artificial disc replacement. There is no demonstrated medical necessity for the continuation of oxycodone for chronic back pain. The chronic use of Oxycodone is not recommended by the CA MTUS; the ACOEM Guidelines or the Official Disability Guidelines for the long term treatment of chronic pain and is only recommended as a treatment of last resort for intractable pain. The prescription of opiates on a continued long-term basis is inconsistent with the CA MTUS and the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain. The current prescription of opioid analgesics is not consistent with evidence based guidelines based on intractable pain. The ACOEM Guidelines updated chapter on chronic pain states "Opiates for the treatment of mechanical and compressive etiologies: rarely beneficial. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major

concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues such as tolerance, opioid-induced hyperalgesia, long-range adverse effects, such as, hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect." ACOEM guidelines state that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time. The long-term use of opioid medications may be considered in the treatment of chronic musculoskeletal pain, if: The patient has signed an appropriate pain contract; Functional expectations have been agreed to by the clinician and the patient; Pain medications will be provided by one physician only; The patient agrees to use only those medications recommended or agreed to by the clinician. ACOEM also notes that "pain medications are typically not useful in the sub-acute and chronic phases and have been shown to be the most important factor impeding recovery of function." Therefore, the request is not medically necessary.

AMBIEN 5MG #30: 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 Chapter, Insomnia.

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--insomnia and Zolpidem.

Decision rationale: Zolpidem/Ambien 10 mg #30 is recommended only for the short-term treatment of insomnia for two to six weeks. The Zolpidem/Ambien 10 mg has been prescribed to the patient for a prolonged period of time. The use of Zolpidem or any other sleeper has exceeded the ODG guidelines. The prescribing physician does not provide any rationale to support the medical necessity of Zolpidem for insomnia or documented any treatment of insomnia to date. The patient is being prescribed the Zolpidem for insomnia due to chronic back pain simply due to the rationale of chronic pain without demonstrated failure of OTC remedies. There is no provided subjective/objective evidence to support the use of Zolpidem 10 mg over the available OTC remedies. The patient has exceeded the recommended time period for the use of this short-term sleep aide. There is no demonstrated functional improvement with the prescribed Zolpidem/Ambien. There is no documentation of alternatives other than Zolpidem have provided for insomnia or that the patient actually requires sleeping pills. The patient is not documented with objective evidence to have insomnia or a sleep disorder at this point in time or that conservative treatment is not appropriate for treatment. There is no evidence that sleep hygiene, diet and exercise have failed for the treatment of sleep issues. There is no demonstrated failure of the multiple sleep aids available OTC. The CA MTUS and the ACOEM Guidelines are silent on the use of sleeping medications. The ODG does not recommend the use of benzodiazepines in the treatment of chronic pain. Zolpidem is not a true benzodiazepine; however, retains some of the same side effects and is only recommended for occasional use and not for continuous nightly use. There is no medical necessity for the prescribed Zolpidem.

NAPROSYN 500MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-inflammatory medications Page(s): 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter--medications for chronic pain and NSAIDs.

Decision rationale: The use of Anaprox/Naproxen 550mg is consistent with the currently accepted guidelines and the general practice of medicine for musculoskeletal strains and injuries; however, there is no evidence of functional improvement or benefit from this NSAID. There is no evidence that OTC NSAIDs would not be appropriate for similar use for this patient. The prescription of Naproxen is not supported with appropriate objective evidence as opposed to the NSAIDs available OTC. The prescription of Naproxen should be discontinued in favor of OTC NSAIDs. There is no provided evidence that the available OTC NSAIDs were ineffective for the treatment of inflammation. The prescription for Naproxen 550mg #60 is not demonstrated to be medically necessary.

FLEXERIL 7.5MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, 128,Chronic Pain Treatment Guidelines muscle relaxants for pain Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-medications for chronic pain; muscle relaxants; cyclobenzaprine.

Decision rationale: The prescription for Flexeril (Cyclobenzaprine) 7.5 mg #60 prn is recommended for the short-term treatment of muscle spasms and not for the long term treatment of chronic pain. The patient has been prescribed muscle relaxers on a long term basis contrary to the recommendations of the CA MTUS. The patient is prescribed muscle relaxers on a routine basis for chronic pain. The muscle relaxers are directed to the relief of muscle spasms. The chronic use of muscle relaxants is not recommended by the CA MTUS, the ACOEM Guidelines or the Official Disability Guidelines for the treatment of chronic pain. The use of muscle relaxants are recommended to be prescribed only briefly in a short course of therapy. There is no medical necessity demonstrated for the use of muscle relaxants for more than the initial short term treatment of muscle spasms. There is a demonstrated medical necessity for the prescription of muscle relaxers on a routine basis for chronic back pain. The cyclobenzaprine was used as an adjunct treatment for muscle and there is demonstrated medical necessity for the Cyclobenzaprine for the cited industrial injury. The continued prescription of a muscle relaxant was not consistent with the evidence based guidelines. The California MTUS states that Cyclobenzaprine is recommended for a short course of therapy. Limited, mixed evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants.

Evidence-based guidelines state that this medication is not recommended to be used for longer than 2 to 3 weeks. There is no demonstrated medical necessity for the prescription of Cyclobenzaprine 7.5mg for the effects of the industrial injury.