

Case Number:	CM14-0104199		
Date Assigned:	07/30/2014	Date of Injury:	01/25/2001
Decision Date:	09/09/2014	UR Denial Date:	06/09/2014
Priority:	Standard	Application Received:	07/07/2014

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 Emergency Medicine and is licensed to practice in New York. 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 patient is a female who was injured on January 25, 2001. The patient continued to experience pain in low back. The physical examination was notable for; decreased range of motion of the back, tenderness to palpation of the lumbar paraspinal area, and tenderness to the bilateral sacroiliac joints. Diagnoses included; bilateral sacroiliac joint dysfunction, failed back surgery syndrome, lumbar radiculopathy, lumbar spondylosis, migraine headaches, and insomnia. The Treatment included; sacroiliac joint injections, medications, and surgery. Requests for medical necessary for Fentanyl patches 100 mcg/ hr, trazodone 100 mg # 75, oxycodone 15 mg, # 150, sumatriptan 100 mg, and retro saddle clips for rollator seat were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Usage of Fentanyl 100 mcg/hr patch is not medically necessary and appropriate.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system).

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

Decision rationale: Fentanyl is an opioid analgesic with potency eighty times that of morphine. It is indicated for management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. The pain cannot be managed by other means (e.g., NSAIDS). Fentanyl should only be used in patients who are currently on opioid therapy for which tolerance has developed. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan, specific for the patient and should follow criteria for use. Criteria for use include; establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened, for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short-term use if first-line options, such as, acetaminophen or NSAIDS have failed. In this case, the patient had been receiving opioid therapy with transdermal fentanyl, and oxycodone since at least February 2013 and had not obtained analgesia. The patient is participating in urine drug testing, but there is no documentation of a signed opioid contract. Criteria for long-term opioid use have not been met, and the request should is not medically necessary.

Retrospective Usage of Trazodon 100mg Qty 75: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain. Decision based on Non-MTUS Citation Official Disabilities Guidelines (ODG) Formulary.

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

Decision rationale: Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. In addition, insomnia treatment should be based on etiology. Though, there are various medications that may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over long-term use. As cognitive behavioral therapy (CBT) should be, an important part of an insomnia treatment plan. Trazodone is a tetracyclic antidepressant. Trazodone is one of the most commonly prescribed agents for insomnia. The side effects of this drug include; nausea, dry mouth, constipation, drowsiness, and headache. There is also, negative next-day effects such as; ease of awakening, and sleep offset insomnia. Tolerance may develop, and cause to rebound insomnia which was found after discontinued use. In this case, the patient had been receiving trazodone for insomnia since at least February 2013. This medication has been used long-term which is contrary to recommendations. In addition there is no documentation that the patient participated in CBT as part of the insomnia treatment, and the request is not medically necessary.

Retrospective Usage of Oxycodone 15mg #150 is not medically necessary and appropriate:
Upheld

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

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

Decision rationale: Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. As Oxycodone is an opioid medication and opioid should be part of; a treatment plan specific for the patient and should follow criteria for use. The criteria for use include; establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from, the opioids if there is no improvement in pain of function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDS have failed. In this case the patient had been receiving opioid therapy with transdermal fentanyl and oxycodone since at least February 2013 and had not obtained analgesia. The patient is participating in urine drug testing, but there is no documentation of a signed opioid contract. Criteria for long-term opioid use have not been met and the request is not medically necessary.

Retrospective Usage of Sumatripan 100mg is not medically necessary and appropriate:
Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head, Triptans, Up To Date: Pathophysiology, clinical manifestations, and diagnosis of migraine in adults.

Decision rationale: The prescription drug Sumatriptan is a triptan and triptans are recommended for migraine sufferers. At marketed doses all oral triptans are effective and well tolerated, though differences among them are in general relatively small but clinically relevant for individual patients. A poor response to one triptan, does not predict a poor response to other agents in that class. In this case there is no documentation that the patient is experiencing headaches. The diagnosis of migraine headache is made only when diagnostic criteria are met as outlined by International Classification of Headache Disorder. Criteria for the diagnosis of migraine headache have not been met and the request is not medically necessary.

Retro-Saddle clips for rollator seat: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines (ODG), Blue Cross of California Medical Policy Durable Medical Equipment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Walking aids (canes, crutches, braces, orthoses,& walkers).

Decision rationale: Saddle clips are used for attaching a saddle bag to a walker, and a rollator is a specific brand of rolling walker or assistive device. Assistive devices for ambulation can reduce pain associated with osteoarthritis. Frames or wheeled walkers are preferable for patients with bilateral disease. In this case there is no documentation of ambulatory dysfunction. The walker is not indicated; therefore the saddle clips are not indicated and the request is not medically necessary.