

Case Number:	CM14-0017227		
Date Assigned:	04/14/2014	Date of Injury:	10/20/1999
Decision Date:	06/03/2014	UR Denial Date:	02/04/2014
Priority:	Standard	Application Received:	02/11/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine, 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 patient is a 61-year-old male with an injury date of 10/20/99. Based on the 01/17/14 progress report provided by the provider, the patient's diagnosis include the following: lumbar strain/sprain, discogenic pain, lumbosacral radiculopathy, chronic pain syndrome, and trochanteric bursitis. The patient claims he has a 10/10 pain in the "low back with radiation into the buttock, and thigh and leg, posterior laterally, again on the left side." The 08/20/13 progress report by [REDACTED] states that the patient had "L4-S1 fusion surgery on the lumbar spine for central and foraminal stenosis at L5-S1, foraminal stenosis at L4-5, and diffuse degenerative disc, but the patient has experienced persistent pain. The patient's post-surgical lumbar MRI (magnetic resonance imaging) findings demonstrate that he has epidural fibrosis mild left sided spinal canal which encircles the thecal sac, and is noted proximally at L4, L5 and S1." The 12/20/13 progress report by the provider states that the patient has more pain standing and walking than sitting. There are no other statements made in regards to the patient's function and pain. The provider is requesting the following: Duragesic patch 75 mg #15, Hydrocodone 10/325 mg #90, Zolpidem 5 mg #30, and Imuhance tablet 450 mg #90. The utilization review determination being challenged is dated 02/04/14 and recommends denial of the Duragesic patch, Hydrocodone, Zolpidem, and Muhance. The provider is the requesting provider, and he provided treatment reports from 08/20/13- 02/14/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

DURAGESIC PATCH 75MG, #15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Duragesic® (fentanyl transdermal system), pg. 44, Section Medications for chronic pain, pgs. 60-61, and Section Criteria for use of Opioids, pgs. 88-89.

Decision rationale: According to the 01/17/13 progress report by the provider, the patient presents with pain in the "low back with radiation into the buttock, and thigh and leg, posterior laterally, again on the left side. The patient also has substantial pain in the groin and buttock, on the left." The request is for Duragesic patch 75 mg #15. The patient was first prescribed Duragesic patch on 10/14/13. The MTUS guidelines state that Duragesic (fentanyl transdermal system) is not recommended as a first line therapy. Duragesic is a trade name of fentanyl transdermal therapeutic system which releases fentanyl, a potent opioid, slowly to the skin. The MTUS requires outcome measures such as current pain, average pain, least pain, and time it takes for medication to take effect and duration of pain relief with medication to be documented. There are no indications of functional improvement from use of the Duragesic patch, nor were any pain scales provided. The request is not certified.

HYDROCODONE 10/325MG, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Medications for chronic pain, and Section Criteria for use of Opioids Page(s): 8-9 Section Medications for chronic pain, pgs. 60-61, and Section Criteria for use of Opioids, pgs. 88-89.

Decision rationale: According to the 01/17/13 progress report by the provider, the patient presents with pain in the "low back with radiation into the buttock, and thigh and leg, posterior laterally, again on the left side. The patient also has substantial pain in the groin and buttock, on the left." The request is for Hydrocodone 10/325 mg #90. The provider first prescribes Hydrocodone on his 10/14/13 progress report. According to MTUS, "when prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." For chronic opiate use, the MTUS guidelines states: "document pain and functional improvement and compare to baseline... Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." None of the reports show any documentation of pain assessment using a numerical scale describing the patient's pain and function. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the patient should be slowly weaned as outlined in the MTUS Guidelines. Therefore, the request is not certified.

ZOLPIDEM 5MG, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Food and Drug Administration (FDA).

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

Decision rationale: According to the 01/17/13 progress report by the provider, the patient presents with pain in the "low back with radiation into the buttock, and thigh and leg, posterior laterally, again on the left side. The patient also has substantial pain in the groin and buttock, on the left." The request is for Zolpidem 5 mg #30. The patient began taking Zolpidem on 10/14/13. The MTUS and ACOEM Guidelines do not address Ambien; however, the Official Disability Guidelines (ODG) states that Zolpidem (Ambien) is indicated for short-term treatment of insomnia with difficulty of sleep onset 7 to 10 days. The ODG guidelines do not recommend long-term use of this medication, as such, the request is not certified.

IMUHANCE TABLET 450MG, #90: 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), Theramine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Theramine, and <http://www.firstpharma.com.lb/product.asp?productid=46&brandid>.

Decision rationale: According to the 01/17/13 progress report by the provider, the patient presents with pain in the "low back with radiation into the buttock, and thigh and leg, posterior laterally, again on the left side. The patient also has substantial pain in the groin and buttock, on the left." The request is for Imuhance tablet 450 mg #90. "Imuhance is a cluster of herbal extracts and natural molecules. It is classified as a Food supplement," according to the [REDACTED] product details. The Official Disability Guidelines (ODG) discusses medical foods and recommends it if there is a specific deficit for the supplement provided. In this case, Imuhance is a cluster of herbal extracts and the content of the product is not known. Therefore, it is not known what it is that this supplement is supposed to supplement. The recommendation is for denial.