MAXIMUS Federal Services

Case Number:	CM14-0121501		
Date Assigned:	08/11/2014	Date of Injury:	10/24/2011
Decision Date:	10/03/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/01/2014

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 Internal 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 38-year-old male who reported an injury of unknown mechanism on 10/24/2011. On 02/19/2014, his diagnoses included chronic pain syndrome, low back pain, lumbar degenerative disc disease, lumbar radiculitis, muscle pain, and numbness. His medications included Opana ER 7.5 mg, Percocet 10/325 mg, Lunesta 3 mg, Zofran 4 mg, and Lyrica 100 mg. His complaints included low back and right leg pain rated at 9/10 without medications and 6/10 with medications. He also reported some pain relief with a spinal cord stimulator. On 07/14/2014, his Opana was increased to 10 mg and Intermezzo 3.5 mg was added to his medication regimen. The rationale for the analgesic medications was that with the medications he was able to be more active spending time with family and traveling. The Lunesta helped him fall asleep and the Intermezzo helped him if he awaked during the night. The Zofran helped with nausea related to the medications. A Request for Authorization dated 07/18/2014 was included in his chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Intermezzo Sub 3.5mg #20: 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), regarding sleep aid

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 (AmbienÂ®)

Decision rationale: The request for Intermezzo Sub 3.5 mg #20 is not medically necessary. Per the Official Disability Guidelines, Zolpidem is a short acting non-benzodiazepine hypnotic which is approved for short-term treatment of insomnia, usually 2 to 6 weeks. While sleeping pills, so called minor tranquilizers, are commonly prescribed for 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 the long-term. This worker had been taking Intermezzo for greater than 2.5 months. This exceeds the recommendations in the guidelines. Additionally, the request did not include frequency of administration. Therefore, this request for Intermezzo Sub 3.5 mg #20 is not medically necessary.

Percocet 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 Opioids Page(s): 74-95.

Decision rationale: The request for Percocet 10/325 mg #90 is not medically necessary. The California MTUS Guidelines recommend ongoing review of opioid use, including documentation of pain relief, functional status, appropriate medication use, and side effects. Long-term use may result in immunological or endocrine problems. There was no documentation in the submitted without chart regarding appropriate long-term monitoring/evaluation, including failed trials of NSAIDs, aspirin, or antidepressants. Additionally, there was no frequency specified in the request. Since this injured worker was taking more than 1 opioid medication, without the frequency, morphine equivalent dosage could not be calculated. Therefore, this request for Percocet 10/325 mg #90 is not medically necessary.

Zofran 4mg #10: 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)

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

Decision rationale: The request for Zofran 4 mg #10 is not medically necessary. Per the Official Disability Guidelines, Zofran is a serotonin 5-HT3 receptor antagonist. It is FDA-approved for nausea and vomiting secondary to chemotherapy and radiation treatment. It is also FDA-approved for postoperative use. Acute use is FDA-approved for gastroenteritis. As with

other antiemetics, routine prophylaxis is not recommended for injured workers in whom there is little expectation that nausea and/or vomiting will occur postoperatively. There was no documentation submitted that this injured worker was being treated with cancer chemotherapy, full body or single dose radiation, or that he was a candidate for surgery with a high expectation of postoperative nausea and vomiting. Additionally, there was no frequency of administration included with the request. Therefore, this request for Zofran 4 mg #10 is not medically necessary.

Lunesta 3mg #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), sleep aid

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental & Stress, Insomnia treatment

Decision rationale: The request for Lunesta 3 mg #30 is not medically necessary. Per the Official Disability Guidelines, pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific components of insomnia should be addressed, including sleep onset, sleep maintenance, sleep quality, and next day functioning. Non-benzodiazepine sedative hypnotics are a first line medication for insomnia. Although direct comparisons between benzodiazepines and the non-benzodiazepine sedative hypnotics have not been studied, it appears that the non-benzodiazepines have similar efficacy to the benzodiazepines with fewer side effects and shorter duration of action. Lunesta has demonstrated reduced sleep latency and sleep maintenance. It is the only benzodiazepine receptor agonist FDA-approved for use longer than 35 days. This injured worker has been using Lunesta for longer than 6 months. Additionally, there was no frequency of administration included with the request. Therefore, this request for Lunesta 3 mg #30 is not medically necessary.

Naproxen 550mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73.

Decision rationale: The request for naproxen 550 mg #60 is not medically necessary. The California MTUS Guidelines recommend NSAIDs at the lowest possible dose for the shortest period of time in patients with moderate to severe osteoarthritis pain. Naproxen is recommended for osteoarthritis or ankylosing spondylitis. There was no evidence in the submitted

documentation that this injured worker had either osteoarthritis or ankylosing spondylitis. It was also noted that he had been taking naproxen for greater than 2 months. Additionally, the request did not include frequency of administration. Therefore, this request for naproxen 550 mg #60 is not medically necessary.

Opana ER 7.5mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 74-95.

Decision rationale: The request for Opana ER 7.5 mg #30 is not medically necessary. The California MTUS Guidelines recommend ongoing review of opioid use, including documentation of pain relief, functional status, appropriate medication use, and side effects. Long-term use may result in immunological or endocrine problems. There was no documentation in the submitted without chart regarding appropriate long-term monitoring/evaluation, including failed trials of NSAIDs, aspirin, or antidepressants. Additionally, there was no frequency specified in the request. Since this injured worker was taking more than 1 opioid medication, without the frequency, morphine equivalent dosage could not be calculated. Therefore, this request for Opana ER 7.5 mg #30 is not medically necessary.