

Case Number:	CM14-0136594		
Date Assigned:	10/14/2014	Date of Injury:	09/27/2005
Decision Date:	12/09/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	08/25/2014

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 66 year old female with an injury date on 09/27/2005. Based on the 06/26/2014 progress report provided by [REDACTED] the diagnoses are: 1. Pure hypercholesterolemia 2. Unspecified essential hypertension 3. Lumbago 4. Sciatica 5. Diabetes mellitus no complication 6. Degeneration of lumbar or lumbosacral intervertebral disc 7. Thoracic or lumbosacral neuritis or radiculitis, unspecified 8. Spondylosis of unspecified site without mention of myelopathy 9. Spinal stenosis of lumbar region 10. Counseling on substance use and abuse 11. Sprain of other specified site of knee and leg 12. Osteoarthritis, localized, primary, lower leg 13. Other joint derangement, not elsewhere classified, lower leg 14. Anxiety about body function or health 15. Insomnia due to medical condition classified elsewhere 16. Spasm of muscle

According to this report, the patient complains of "lower back pain which is rated as 6.5 out of 10 on the VAS scale. Pain is constant that can increase to a sharp pain that is shooting in sensation radiating into her leg." Exacerbating factors include sitting or lifting objects. The only alleviating factors are aquatic therapy, stationary bike, physical therapy, and oral pain medications. Patient's current pain is rated as 4 out of 10 on the VAS scale on a daily basis with pain medication. Exam of the lumbar spine reveals restricted lumbar range of motion due to pain. Tenderness is noted with palpation of the facets and sacroiliac joints. Straight leg raise and Patrick's test are positive. Motor testing is 2/5 in bilateral lower extremities. Exam of the left knee reveals tenderness at the joint line. Range of motion is 0 to 100 degrees. Crepitus is noted during palpations of the patella. Mc Murray test is positive. There were no other significant findings noted on this report. The utilization review denied the request on 07/22/2014. [REDACTED] is the requesting provider and he provided treatment reports from 01/30/2014 to 07/14/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325 mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78;88-89.

Decision rationale: According to the 06/26/2014 report by [REDACTED] this patient presents with lower back pain which is rated as 6.5 out of 10 on the VAS scale. The treater is requesting Percocet 10/325mg #60. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Percocet was first prescribed on 04/27/2013; it is unknown exactly when the patient initially started taking this medication. A urine toxicology report on 04/02/2014 was provided for review. Review of report shows documentation of analgesia with ranging from 6.5/10 to 4/10. UDS was obtained. Other than these, the documentation lack discussion regarding specific ADL's, side effects, other opiates management issues such as CURES, behavioral issues. Outcomes measures are not documented as required by MTUS. No valid instruments are used to measure the patient's function which is recommended once at least every 6 months per MTUS. Change in work status, or return to work attributed to use of Percocet were not discussed. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the patient should be slowly weaned as outlined in MTUS Guidelines. The request is not medically necessary.

Fentanyl patch 50 mcg/hr #10: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic and Medications for chronic pain Page(s): 44, 60-61; 78, 88-89.

Decision rationale: According to the 06/26/2014 report by [REDACTED] this patient presents with lower back pain which is rated as 6.5 out of 10 on the VAS scale. The treater is requesting Fentanyl patch 50mcg/hr #10. The MTUS Guidelines page 44 states 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. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or

validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Fentanyl patch was first prescribed on 02/21/2013; it is unknown exactly when the patient initially started taking this medication. Review of report shows documentation of analgesia with ranging from 6.5/10 to 4/10. UDS was obtained. Other than these, the documentation lack discussion regarding specific ADL's, side effects, other opiates management issues such as CURES, behavioral issues. Outcomes measures are not documented as required by MTUS. No valid instruments are used to measure the patient's function which is recommended once at least every 6 months per MTUS. Change in work status, or return to work attributed to use of Percocet were not discussed. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the patient should be slowly weaned as outlined in MTUS Guidelines. The request is not medically necessary.

Lunesta 2 mg #60: 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) Lunesta under Insomnia, Pain chapter

Decision rationale: According to the 06/26/2014 report by [REDACTED] this patient presents with lower back pain which is rated as 6.5 out of 10 on the VAS scale. The treater is requesting Lunesta 2 mg #60. Regarding Lunesta, the MTUS and ACOEM Guidelines do not discuss, but ODG Guidelines discuss Lunesta under insomnia and state "Lunesta has demonstrated reduced sleep latency and sleep maintenance. The only benzodiazepine receptor agonist FDA approved for use longer than 35 days." Under Stress chapter, it states "Not recommended for long-term use, but recommended for short-term use." Review of reports indicates Lunesta was first prescribed on 06/14/2013; the patient has been on this medication for a long-term, which is not recommended. The request is not medically necessary.

Tizanidine 4 mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASTICITY/ANTISPASMODIC DRUGS Page(s): 66.

Decision rationale: According to the 06/26/2014 report by [REDACTED] this patient presents with lower back pain which is rated as 6.5 out of 10 on the VAS scale. The treater is requesting Tizanidine 4 mg #90. The MTUS guidelines page 66, "Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain." The patient was first prescribed this medication on

06/14/2013. In this case, given the patient's chronic pain, use of this medication may be indicated. However, the treater does not explain how this medication is being used with what effectiveness. The MTUS guidelines page 60 require documentation of medication efficacy when it is used for chronic pain. Given the lack of such documentation, the request is not medically necessary.