

Case Number:	CM14-0173144		
Date Assigned:	10/23/2014	Date of Injury:	02/04/2009
Decision Date:	12/16/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/20/2014

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:

This is a 64-year-old female patient who reported an industrial injury on 2/4/2009, almost six (6) years ago, attributed to the performance of her usual and customary job tasks. The patient underwent surgical intervention, which included lumbar laminectomy, bilateral foraminotomy L2, L3, L4 and laminotomy, bilateral foraminotomy L4 and L5 on 8/24/2009. Patient had a Lap Band procedure on 6/2/2011. The patient is status post L3-L5 anterior posterior fusion. 6/25/2014. The patient is being treated subsequent to the L3-L5 anterior posterior fusion with the initiation of physical therapy. The patient was fitted for an AFO as she complained of a right foot drop. The patient continued to complain of lower back pain radiating to the right lower extremity. The patient is being treated postoperatively with high dose opioids. The treating diagnoses included lumbar; thoracic/lumbar radiculitis; lumbosacral spondylitis; and lumbar disc displacement. The treatment plan included fentanyl patch 12 mcg/hr #15; oxycodone 20 mg-middle #120 mil; gabapentin 300 mg/6 mil #940 mil; omeprazole 20 mg #60; glycerin 2.1 mg #30; trial of amitriptyline 25 mg #30; and a four wheeled walker with a seat.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fentanyl Patch 12mcg / Hr #15: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 114-116, Chronic Pain Treatment Guidelines opioids Page(s): 74-97.

Decision rationale: Evidence-based guidelines recommend short-term use of opioids for the management of chronic nonmalignant moderate to severe pain. Long-term use is not recommended for nonmalignant pain due to addiction, dependency, intolerance, abuse, misuse, and/or side effects. Ongoing opioid management criteria are required for long-term use with evidence of reduce pain and improve function as compared to baseline measurements or a return to work. The patient is being treated six (6) months status post date of surgery for an anterior posterior fusion. The patient should be titrated down and off opioids postoperatively as recommended by evidence-based guidelines. The prescription for Fentanyl patches 12 mcg/hr #15 was prescribed as a long acting opioid analgesic for the treatment of chronic back pain contrary to the recommendation of evidence-based guidelines. There is no objective evidence provided to support the continued prescription of opioid analgesics for chronic back pain based on the objective findings documented. There is no documented functional improvement with the currently prescribed Fentanyl patches. The chronic use of Fentanyl patches is not recommended by the CA MTUS; the ACOEM Guidelines, or the Official Disability Guidelines for the long-term treatment of chronic back pain or postoperative 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 and OTC analgesics for the treatment of chronic back pain. 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. There is no clinical documentation with objective findings on examination to support the medical necessity of Fentanyl patches for the treatment of chronic back pain postoperatively. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with Fentanyl patches. There is no demonstrated medical necessity for the prescribed fentanyl patches 12 mcg/hr #15.

Oxycodone 20mg/ml #120ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management.

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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chapter 6 pages 114-16; Official Disability Guidelines (ODG) chapter on pain, opioids, criteria for use

Decision rationale: 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 demonstrated medical necessity for prescribed liquid form of the opioid. 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 20 mg/ml #120 ml is being prescribed as opioid analgesics for the treatment of chronic postoperative 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 for a period of time longer than 6-8 weeks post operatively. 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 state, "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 note, "Pain medications are typically not useful in the subacute and chronic phases and have been shown to be the most important factor impeding recovery of function." There is no demonstrated medical necessity for the continued prescription of oxycodone 20 mg/ml #120ml.

Omeprazole 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk..

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; NSAIDs

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines section on anti-inflammatory medications and gastrointestinal symptoms states; "Determine if the patient is at risk for gastrointestinal events." The medical records provided for review do not provide additional details in regards to the above assessment needed for this request. No indication or rationale for gastrointestinal prophylaxis is documented in the records provided. There are no demonstrated or documented GI issues attributed to NSAIDs for this patient. The patient was prescribed Omeprazole routine for prophylaxis with opioid analgesics. The chronic prescription of proton pump inhibitors is noted to lead to osteoporosis and decreased magnesium levels. The protection of the gastric lining from the chemical effects of NSAIDs is appropriately accomplished with the use of the proton pump inhibitors such as Omeprazole. The patient is documented to be taking no NSAIDs and there were no documented GI risks for this patient. There is no industrial indication for the use of Omeprazole due to "stomach issues" or stomach irritation. The proton pump inhibitors provide protection from medication side effects of dyspepsia or stomach discomfort brought on by NSAIDs. The use of Omeprazole is medically necessary if the patient were prescribed conventional NSAIDs and complained of GI issues associated with NSAIDs. Whereas, 50% of patient taking NSAIDs may complain of GI upset, it is not clear that the patient was prescribed Omeprazole automatically. The prescribed opioid analgesic, not an NSAID, was accompanied by a prescription for Omeprazole without documentation of complications. There were no documented GI effects of the NSAIDs to the stomach of the patient and the Omeprazole was dispensed or prescribed routinely. The prescription for Omeprazole 20 mg #60 is not demonstrated to be medically necessary.

Four Wheel Walker with seat: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation general disciplinary guidelines for the practice of medicine

Decision rationale: There was no rationale with any supportive objective evidence provided by the requesting physician to support the medical necessity of the requested four wheel Walker with the seat six (6) months after the date of surgery. There was no objective evidence provided that the patient would be significantly disabled that the previously provided to wheel Walker was insufficient. There was no demonstrated medical necessity for the prescribed four wheel Walker with the seat for the postoperative care of the patient s/p anterior posterior lumbar fusion six (6) months after the date of surgery. The patient is documented to be ambulating efficiently with a two wheeled walker and is participating in rehabilitation. There is no demonstrated medical necessity for the requested four wheeled Walker with the seat.