

Case Number:	CM14-0073917		
Date Assigned:	08/06/2014	Date of Injury:	02/07/2002
Decision Date:	10/08/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/21/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 59-year-old female who reported an injury on 02/07/2002 caused by an unspecified mechanism. The injured worker's treatment history included medications, surgery, and MRI studies. The injured worker had a urine drug screen on 11/25/2013 that was positive for Opioid usage. The injured worker was evaluated on 01/27/2014 and it was documented the injured worker complained of persistent low back pain mostly radiating to the left lower extremity rated at 8/10. Objective findings revealed spasm in the lumbar paraspinal muscles with stiffness noted in the lumbar spine. Medications included Ambien, Lyrica, Norco, Phenergan, Senokot, Skelaxin, Voltaren gel, Topamax, Kadian, and Lyrica. Diagnosis included low back pain, lumbosacral neuritis NOS, abnormality of gait, lumbar facetal syndrome, thoracic spine pain without radiculopathy, and chronic pain. The request for authorization was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Kadian 20mg, qty 60 DOS unspecified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

Decision rationale: The request for retrospective Kadian 60 mg # 60 DOS unspecified is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that criteria for use for ongoing- management of opioids include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There was lack of evidence of opioid medication management and average pain, intensity of pain, or longevity, of pain relief. In addition, the request does not include the frequency. In addition there was no documented evidence of conservative care such as, pain medication management or home exercise regimen outcome improvements noted for the injured worker. The request failed to include duration and frequency of medication. As such, the request is not medically necessary.

Hydrocodone 10/325mg, qty 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

Decision rationale: The request for Hydrocodone 10/325 mg # 120 is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that criteria for use for ongoing- management of opioids include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. There was lack of evidence of opioid medication management and average pain, intensity of pain, or longevity, of pain relief. In addition, the request does not include the frequency. In addition there was no documented evidence of conservative care such as, physical therapy or home exercise regimen outcome improvements noted for the injured worker. The request failed to include duration and frequency of medication. As such, the request is not medically necessary.

Ambien 6.25mg, qty 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, Integrated Treatment/Disability Duration Guidelines, Stress and Mental Illness Chapter

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

Decision rationale: The request for Ambien 6.25 mg # 20 is not medically necessary. The Official Disability Guidelines (ODG) states that Ambien is a prescription short-acting non benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and

often is hard to obtain. Various medications 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 the long-term. The documentation that was submitted for review lacked evidence on the duration the injured worker has been on Ambien. In addition, the request did not include the frequency or duration for the medication for the injured worker. The guidelines do not recommend Ambien for long-term use. Therefore, the continued use of Ambien is not supported. As such the request is not medically necessary.

Skelaxin 800mg, qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant & Skelaxin Page(s): 63, 64.

Decision rationale: The requested service is not medically necessary. According California (MTUS) Chronic Pain Medical Guideline recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain (LBP). Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond non-steroidal anti-inflammatory drugs (NSAIDs) in pain and overall improvement. The guideline also state Skelaxin is recommended with caution as a second-line option for short-term pain relief in patients with Chronic LBP. Metaxalone (marketed by King Pharmaceuticals under the brand name Skelaxin) is a muscle relaxant that is reported to be relatively non-sedating. The documentation submitted lacked evidence of outcome measurements of conservative care such as prior physical therapy sessions and medication pain management. There was lack of documentation provided on her long term-goals of functional improvement of her home exercise regimen. In addition, the request lacked frequency, and duration of the medication. As, such, the request for Skelaxin 800 mg #1 is not medically necessary.

Topamax 100mg, qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs Page(s): 16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti epilepsy Drugs (AEDS) Page(s): 16.

Decision rationale: The requested is not medically necessary. Per California Medical Treatment Utilization Schedule (MTUS) Guidelines state that Topamax is an anti-epilepsy drug AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The documentation submitted had lack of evidence of the

efficacy of the requested drug after the injured worker takes the medication. In addition, the request did not include frequency of the medication. Given the above, the request for Topamax 100mg # 90 is not medically necessary.

Phenargan 25mg, qty 60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/phenargan.html>

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

Decision rationale: The request for Phenergan 25 mg # 60 is not medically necessary. The Official Disability Guidelines (ODG) do not recommend Phenergan/Zofran for nausea and vomiting secondary to chronic opioid use. Nausea and vomiting is common with the use of opioids. Side effects tend to diminish over days to weeks of continued exposure. Studies of opioid adverse effects including nausea and vomiting are limited to short-term duration (less than four weeks) and have limited application to long-term use. If nausea and vomiting remains prolonged, other etiologies of these symptoms should be evaluated for. The differential diagnosis includes gastro paresis (primarily due to diabetes). Current research for treatment of nausea and vomiting as related to opioid use primarily addresses the use of antiemetics in patients with cancer pain or those utilizing opioids for acute/postoperative therapy. Recommendations based on these studies cannot be extrapolated to chronic non-malignant pain patients. There is no high-quality literature to support any one treatment for opioid-induced nausea in chronic non-malignant pain patients. The documents submitted does not warrant the need for the injured worker need Phenergan. Additionally, the documentation provided does not indicate the injured worker having a diagnoses of cancer or acute/postoperative therapy. Given the above, the request is not medically necessary.