

Case Number:	CM15-0108495		
Date Assigned:	06/11/2015	Date of Injury:	09/30/2003
Decision Date:	07/29/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	06/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Anesthesiology

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 56-year-old female patient who sustained an industrial injury on 09/30/2003. A primary treating follow up visit dated 12/17/2014 reported the patient having been walking more and using a wheelchair less. Examination showed good sensation in bilateral legs and good strength of dorsiflexion of both foot and ankle bilaterally. There is an absent left Achilles reflex. The recommendation is do have the patient undergo radiography study of lumbar spine. That following visit on 01/14/2015 reported chief complaints of: knee pain, chronic pain syndrome, lumbosacral radiculitis, lumbar post-laminectomy syndrome, and degeneration of cervical intervertebral disc. The patient has been approved form home physical therapy and now is searching for a business who offers such. She states the medications do help her as she is healing from surgery; now more mobile with a walker. She has attempted at weaning from the Oxycodone, but often waits too long to medicate and the pain is out of control. Current medications are Fentanyl 125 mcg, Gabapentin 300mg, Oxycodone 30mg, Trazadone, and Ambien. The follow up visit dated 02/08/2015 reported the patient doing better; she is out of a scooter and using a walker. Physical therapy has not initiated as of yet. She is with subjective complaint of having low back pain that radiates to the bilateral lower extremities. The subjective complaint, objective assessment and medication regimen continued throughout March 2015. The patient is noted with slow improvement and is now able to walk distance.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone 30 mg #210: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to ODG, 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. When these drugs do not satisfactorily reduce pain, opioids for moderate to severe pain may be added. Oxycodone (Oxycontin) is a long-acting opioid analgesic. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional improvement from previous usage, or response to ongoing opiate therapy. Medical necessity of the requested opioid analgesic has not been established. Of note, discontinuation of an Oxycodone should include a taper, to avoid withdrawal symptoms. The requested Oxycontin is not medically necessary.

Fentanyl 75mcg/hr transdermal patch Qty:10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic Page(s): 44.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the ODG and MTUS, Fentanyl is a long-acting narcotic analgesic used to manage both acute and chronic pain. Fentanyl is an opioid analgesic with a potency of eighty times that of Morphine. Fentanyl transdermal (Duragesic) patches are indicated for the management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. Duragesic patches should only be used in patients who are currently on opioid therapy for which tolerance has developed. Patches are worn for a 72-hour period. In this case, the treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. There is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Gabapentin 300 mg #270 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Page(s): 16-18.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 18. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) AEDs.

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. The records documented that the patient has neuropathic pain related to her chronic low back condition. In this case, there is no documentation of the medication's effectiveness as documented with decreased pain and increased functional status. Medical necessity for Neurontin has not been established. Of note, discontinuation of a Gabapentin should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Hydroxyzine HCL 25 mg #90 with 5 refills: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Anxiety medications in chronic pain.

Decision rationale: Hydroxyzine (Atarax) is used as a sedative to treat anxiety and tension. It also acts as an antihistamine and used to treat allergic skin reactions. In this case, there is no documentation that the patient has significant anxiety or allergic conditions to warrant the use of this medication. Medical necessity for Hydroxyzine has not been established. The requested medication is not medically necessary.

Zolpidem 10 mg #30 with 3 refills: 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), Pain Chapter.

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

Decision rationale: Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Ambien can be habit-forming, and may impair function and memory more than opioid analgesics. There is also concern that Ambien may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology, and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case, there is lack of documentation supporting objective functional improvement (improved Epworth sleep scale). There is no documentation provided indicating medical necessity for Ambien. The requested medication is not medically necessary.