

Case Number:	CM15-0136793		
Date Assigned:	07/24/2015	Date of Injury:	11/30/1995
Decision Date:	09/21/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/14/2015

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: California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 66 year old male who sustained an industrial injury on November 30, 1995. He has reported low back pain radiating down the lateral aspect of his left lower extremity to the knee and has been diagnosed with radiculopathy lumbar spine, lumbar spine pain, degenerative disc disease, and failed back syndrome lumbar. Treatment has included medications, injection, physical therapy, and chiropractic care. Straight leg raise on the left was 30 degrees and was positive. There was pain noted over the lumbar intervertebral spaces on palpation. Palpable twitch positive trigger points were noted in the lumbar spine. There was pain with range of motion. There was pain with lumbar extension. Heel and toe stands were weak on the right and left. The treatment request included Duragesic, Oxycodone, Lunesta, and Visteral.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duragesic 25mcg #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system) Page(s): 44, 47.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 76-78, 88,89, 80,81.

Decision rationale: The patient presents with low back pain radiating to the lateral aspect of the left lower extremity. The request is for DURAGESIC 25 MCG #15. Physical examination to the lumbar spine on 01/09/15 revealed tenderness to palpation over the intervertebral spaces. Straight leg raising test on the left was positive at 30 degrees. Patient's treatment have included medication, physical and chiropractic therapy, image studies and ESI injections with benefits. Per 02/10/15 progress report, patient's diagnosis include radiculopathy L/S, deg disc disease, Lumb, and failed back synd, Lumb. Patient's medications, per 05/15/15 progress report include Duragesic, Lunesta, Neurontin, Oxycodone, Nexium, and Vistaril. Patient is permanent and stationary. MTUS guidelines page 44 recommends Fentanyl transdermal (Duragesic) for management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. 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 4A's (analgesia, ADLs, adverse side effects, and adverse 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. MTUS p80,81 also states regarding chronic low back pain: "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." Long-term use of opiates may be indicated for nociceptive pain per MTUS, stating, "Recommended as the standard of care for treatment of moderate or severe nociceptive pain (defined as pain that is presumed to be maintained by continual injury with the most common example being pain secondary to cancer)." However, this patient does not present with pain that is presumed to be maintained by continual injury. Treater has not discussed this request. No RFA was provided either. UR letter dated 06/24/15 modified the request to 11 patches. The patient has been prescribed Duragesic Patch since at least 12/10/14. MTUS requires appropriate discussion of the 4A's, however, in addressing the 4A's, treater does not discuss how Duragesic Patch significantly improves patient's activities of daily living with specific examples of ADL's. Analgesia is discussed, specifically showing significant pain reduction with use of Duragesic Patch. UDS results dated 02/03/15 were consistent with patient's medications, however, no CURES or opioid contracts were provided. Furthermore, MTUS does not support the use of opiates for chronic low back pain, only supporting it for a short-term relief. This request does not meet guideline recommendations and therefore, it 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), Pain.

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 Chapter under Eszopicolone (Lunesta).

Decision rationale: The patient presents with low back pain radiating to the lateral aspect of the left lower extremity. The request is for LUNESTA 3 MG #30. Physical examination to the lumbar spine on 01/09/15 revealed tenderness to palpation over the intervertebral spaces. Straight leg raising test on the left was positive at 30 degrees. Patient's treatment have included medication, physical and chiropractic therapy, image studies and ESI injections with benefits. Per 02/10/15 progress reprot, patient's diagnosis include radiculopathy L/S, deg disc disease, Lumb, and failed back synd, Lumb. Patient's medications, per 05/15/15 progress report include Duragesic, Lunesta, Neurontin, Oxycodone, Nexium, and Vistaril. Patient is permanent and stationary. ODG-TWC, Mental & Stress Chapter states: "Eszopicolone (Lunesta): Not recommended for long-term use, but recommended for short-term use. See Insomnia treatment. See also the Pain Chapter. Recommend limiting use of hypnotics to three weeks maximum in the first two months of injury only, and discourage use in the chronic phase... The FDA has lowered the recommended starting dose of eszopiclone (Lunesta) from 2 mg to 1 mg for both men and women." Treater has not discussed this request. No RFA was provided either. Review of the medical records provided indicate that the patient has been utilizing Lunesta since at least 12/10/14. ODG guidelines however, recommends short-term use of up to 3 weeks. The request for 30 tablets in addition to prior prescriptions exceeds MTUS intended short-term use of this medication. Therefore, the request IS NOT medically necessary.

Oxycodone 10mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 76-78, 88,89.

Decision rationale: The patient presents with low back pain radiating to the lateral aspect of the left lower extremity. The request is for OXYCODONE 10 MG #120. Physical examination to the lumbar spine on 01/09/15 revealed tenderness to palpation over the intervertebral spaces. Straight leg raising test on the left was positive at 30 degrees. Patient's treatment have included medication, physical and chiropractic therapy, image studies and ESI injections with benefits. Per 02/10/15 progress report, patient's diagnosis include radiculopathy L/S, deg disc disease, Lumb, and failed back synd, Lumb. Patient's medications, per 05/15/15 progress report include Duragesic, Lunesta, Neurontin, Oxycodone, Nexium, and Vistaril. Patient is permanent and stationary. 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 adverse 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. MTUS p77 states, "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." Pages 80, 81 of MTUS also states "There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant radiculopathy," and for chronic back pain, it "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." MTUS p90,

maximum dose for Hydrocodone, 60mg/day. The treater does not specifically discuss this request. The utilization review letter dated 6/24/15 modified the request #90 recommending a taper. The progress reports from 12/10/14 through 6/15/15 all list Oxycodon but does not adequately discuss its impact on the patient's pain and function. No before and after pain scales are used for analgesia although there is a statement that there is significant pain reduction. No ADL's are discussed showing specific functional improvement. While UDS is provided as consistent, no adverse effect and other measures of aberrant behavior are discussed. Outcome measures are not discussed and no validated instruments are used showing functional improvement as required by MTUS. Furthermore, MTUS does not support long-term use of opiates for chronic low back pain and on-going use of opiates does not appear appropriate for this patient's condition. The request IS NOT medically necessary.

Vistaril 25mg #540: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Mental Illness and Stress chapter, under Insomnia Treatments.

Decision rationale: The patient presents with low back pain radiating to the lateral aspect of the left lower extremity. The request is for VISTARIL 25 MG #540. Physical examination to the lumbar spine on 01/09/15 revealed tenderness to palpation over the intervertebral spaces. Straight leg raising test on the left was positive at 30 degrees. Patient's treatment have included medication, physical and chiropractic therapy, image studies and ESI injections with benefits. Per 02/10/15 progress report, patient's diagnosis include radiculopathy L/S, deg disc disease, Lumb, and failed back synd, Lumb. Patient's medications, per 05/15/15 progress report include Duragesic, Lunesta, Neurontin, Oxycodone, Nexium, and Vistaril. Patient is permanent and stationary. ODG guidelines has the following regarding anti-Histamine for insomnia: (4) Over-the-counter medications: Sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. Side effects include urinary retention, blurred vision, orthostatic hypotension, dizziness, palpitations, increased liver enzymes, drowsiness, dizziness, grogginess and tiredness. ODG discusses Hydroxyzine, Pain chapter under opioid weaning and for treatment of anxiety. Treater has not provided medical rationale for the request. No RFA was provided either. Review of the medical records provided indicate that the patient received prescriptions for Vistaril on 05/15/15 and 06/15/15. However, it is not known why this medication is prescribed. There is no discussion of insomnia, anxiety, or weaning of opiates for which this medication may be indicated. Additionally, ODG states that tolerance develops within a few days, thus not providing long-term support. In this case, the request is for #540, a long-term use not supported by the guidelines. Therefore, the request IS NOT medically necessary.