

Case Number:	CM15-0139270		
Date Assigned:	07/29/2015	Date of Injury:	06/11/1997
Decision Date:	09/18/2015	UR Denial Date:	07/08/2015
Priority:	Standard	Application Received:	07/17/2015

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: Preventive Medicine, Occupational Medicine

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 50 year old male who sustained an industrial injury on 6/11/97. The diagnoses have included cervical spine disc syndrome with strain and sprain disorder; thoracic spine strain and sprain disorder and lumbosacral spine disc syndrome with train and sprain disorder, and chronic pain syndrome with idiopathic insomnia. Co-morbid conditions include obesity (BMI 34.3) and the recent onset of Langerhans syndrome. Treatment to date has included medications. The provider's progress note, dated 7/9/2015, reported the injured worker had continued complaints of neck and low back pain with associated weakness, paresthesias and generalized discomfort. Medications provide only partial improvement in pain On exam the injured worker had reduced range of motion of the entire spine and in all segments, reduced sensation and strength in all four limbs, tender, painful bilateral cervical, thoracic and lumbosacral paraspinal muscular spasms, absent bilateral deep tendon reflexes and positive straight leg test. The request was for ambien 10mg #30; percocet 10/325mg #120; oxycontin 80mg #120 and soma 350mg #120.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #30: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Schutte-Rodin S, et al. Clinical Guideline for the Evaluation and Management of Chronic Insomnia in Adults. J Clin Sleep Med 2008; 4 (5): 487- 504.

Decision rationale: Zolpidem (Ambien, Ambien CR) is a short-acting benzodiazepine receptor agonist medication. It is indicated for short-term (usually about two to six weeks) treatment of insomnia. It is very effective in initiating sleep but has not adequately demonstrated effectiveness in maintaining sleep, unless delivered in a controlled-release (CR) form. Long-term use of zolpidem is associated with drug tolerance, drug dependence, rebound insomnia, and CNS-related adverse effects. Insomnia is defined by the American Academy of Sleep Medicine (AASM) as the subjective perception of difficulty with sleep initiation, duration, consolidation, or quality that occurs despite adequate opportunity for sleep, and that results in some form of daytime impairment. It is the most prevalent sleep disorder in the general population. It requires a full work-up to understand its etiology and to direct therapy. The AASM guideline recommends any pharmacologic treatment for chronic insomnia be accompanied by cognitive and behavioral treatments. Additionally, it recommends use of benzodiazepines or benzodiazepine receptor agonist medications be used short term followed by other sedating agents such as sedating antidepressants and atypical antipsychotics. This patient has been taking benzodiazepines for longer than 6 weeks and is still experiencing frequent nighttime awakenings. A full evaluation for the etiology for the patient's chronic insomnia has not been done. The medical necessity for continued use of this medication has not been established.

Percocet 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-9, Chronic Pain Treatment Guidelines Medications for chronic pain; Opioids; Weaning of Medications Page(s): 60-1, 74-96, 124.

Decision rationale: Oxycodone/APAP (Percocet) is a combination medication made up of the semisynthetic opioid, oxycodone, and acetaminophen, better known as tylenol. It is indicated for treatment of moderate to severe pain and is available in immediate release and controlled release forms. Maximum dose according to the MTUS is limited to 4 gm of acetaminophen per day which is up to 90-180 mg/day of oxycodone depending on the formulation. If being used to treat neuropathic pain, then it is considered a second-line treatment (first-line are antidepressants and anticonvulsants), however, there are no long-term studies to suggest chronic use of opioids for neuropathic pain. If treating chronic low back pain, opioids effectiveness is limited to short-term pain relief (up to 16 weeks) as there is no evidence of long-term effectiveness. It is known that long-term use of opioids is associated with hyperalgesia and tolerance. According to the MTUS,

opioid therapy for control of chronic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. Success of this therapy is noted when there is significant improvement in pain or function. It is important to note, however, the maximum daily dose of opioids, calculated as morphine equivalent dosing from use of all opioid medications, is 120 mg per day. The major risks of opioid therapy are the development of addiction, overdose and death. The pain guidelines in the MTUS directly address opioid use by presenting a number of recommendations required for providers to document safe use of these medications. Even though the present provider is following these recommendations, is appropriately monitoring this patient and notes the partial improvement in pain control with the use of opioid preparations, the total dose of opioids (from OxyContin and Percocet use) is 420 mg daily morphine equivalent dose. Despite the documented effectiveness in this dose this is significantly above the maximum dosing recommended. Even with use of these high opiate doses the patient is still having significant pain. For patient safety the dose should be lowered to a more acceptable and safe level. Weaning is recommended. Medical necessity for continued use of this medication at this dosage has not been established.

Oxycontin 80mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-9, Chronic Pain Treatment Guidelines Medications for chronic pain; Opioids; Weaning of Medication Page(s): 60-1, 74-96, 124.

Decision rationale: Oxycodone (OxyContin) is a semisynthetic opioid indicated for treatment of moderate to severe pain available in immediate release (Oxycodone IR) and controlled release forms. According to the MTUS, opioid therapy for control of chronic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. When being used to treat neuropathic pain it is considered a second-line treatment (first-line medications are antidepressants and anticonvulsants), however, there are no long-term studies to suggest chronic use of opioids for neuropathic pain. It is known that long-term use of opioids is associated with hyperalgesia and tolerance. Success of this therapy is noted when there is significant improvement in pain or function. It is important to note, however, the maximum daily dose of opioids, calculated as morphine equivalent dosing from use of all opioid medications, is 120 mg per day. The major risks of opioid therapy are the development of addiction, overdose and death. The pain guidelines in the MTUS directly address opioid use by presenting a number of recommendations required for providers to document safe use of these medications. Even though the present provider is following these recommendations, is appropriately monitoring this patient and notes the partial improvement in pain control with the use of opioid preparations, the total dose of opioids (from OxyContin and Percocet use) is 420 mg daily morphine equivalent dose. Despite the documented effectiveness in this dose this is significantly above the maximum dosing recommended. Even with use of these high opiate doses the patient is still having significant pain. For patient safety the dose should be lowered to a more acceptable and safe level. Weaning is recommended. Medical necessity for continued use of this medication at this dosage has not been established.

Soma 350mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Carisoprodol; Muscle relaxants (for pain); Weaning of Medications Page(s): 29, 63-5, 124.

Decision rationale: Carisoprodol is a centrally acting skeletal muscle relaxant. This class of medications can be helpful in reducing pain and muscle tension thus increasing patient mobility. Muscle relaxants as a group, however, are recommended for short-term use only as their efficacy appears to diminish over time. In fact, Carisoprodol is not recommended by the MTUS for use to treat pain as it is metabolized to meprobamate, a barbiturate and a schedule-IV controlled substance. If this medication is used, it is only indicated for short-term use. This patient has been on carisoprodol therapy for over 4 months and still has muscle spasms. There is no indication to continue use of this medication. Since a withdrawal syndrome has been associated with use of this medication weaning is recommended. Medical necessity has not been established. Therefore, the request is not medically necessary.