

Case Number:	CM15-0168377		
Date Assigned:	09/09/2015	Date of Injury:	05/31/2000
Decision Date:	10/23/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	08/26/2015

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 45 year old male, who sustained an industrial injury on 5-31-2000. The current diagnoses are lumbago and long-term use of medication. According to the progress report dated 6-30-2015, the injured worker complains of low back and bilateral hip pain. On a subjective pain scale, he rates his pain 3 out of 10 with medications and 10 out of 10 without. Per notes, he is able to cook, do laundry, garden, shop, bathe, dress, manage medications, drive, and brush teeth. The physical examination reveals tenderness over the lumbar spine and facet joint. Range of motion with flexion and extension is decreased. The current medications are Viagra, Cymbalta, Norco, Mobic, OxyContin, Testosterone, Soma, Methadone, and Duragesic. Urine drug screen from 6-30-2015 was consistent with prescribed medications. There is documentation of ongoing treatment with Duragesic, Mobic, Oxycodone, OxyContin, and Soma since at least 2014. Treatment to date has included medication management. Work status is described as permanently disabled. The request for Cialis, Duragesic, Mobic, Oxycodone, OxyContin, and Soma has been submitted. The original utilization review (8-20-2015) partially approved a request for Duragesic #10 with no refills (original request for #10 with 1 refill), Oxycodone #180 with no refills (original request for #180 with 1 refill), OxyContin #60 with no refills (original request for #90 with 1 refill), and Soma #90 with no refills (original request for #120 with three refills), and a non-certification for Cialis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cialis 5mg, #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 Chapter - Opioids for chronic pain; National Guideline Clearinghouse - Guidelines on male sexual dysfunction: erectile dysfunction and premature ejaculation, page 54.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine (2014).

Decision rationale: Cialis (Tadalafil) is a medication used to treat erectile dysfunction and pulmonary arterial hypertension. It acts by inhibiting PDE-5 (cyclic guanosine monophosphate (cGMP)-specific phosphodiesterase-type 5), increasing cGMP to allow smooth-muscle relaxation and inflow of blood into the penis. In this case, the documentation does not indicate a clear description of subjective complaints of sexual dysfunction. In addition, it is not clear if the patient's reported erectile dysfunction is suspected to be a side effect of opioid use. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Duragesic 50mcg/hr, #10 with 1 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter - Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: Fentanyl is an opioid analgesic with a potency of eighty times that of Morphine. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. According to the ODG and MTUS, Fentanyl is a long-acting narcotic analgesic used to manage both acute and chronic pain. 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. In this case, the Duragesic patches exceed the recommended Morphine Equivalent Dosage (MED) limit for non-malignant pain. In addition, this patient had a recent insertion of a spinal cord stimulator, which should decrease some of the pain. Guidelines do not support continuation of this medication at this dosage. Medical necessity of the requested medication 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.

Mobic 15mg, #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Mobic (Meloxicam), is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, acute low back pain (LBP), short-term pain relief in chronic LBP, and short-term improvement of function in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain in this condition. In this case, the patient has chronic pain and the use of Mobic may help to decrease the patient's reliance on opioid medication. Medical necessity for the requested medication has been established. The requested medication is medically necessary.

Oxycodone 30mg, #180 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the ODG and MTUS, Oxycodone is a short-acting opioid analgesic. Opioid drugs are available in various dosage forms and strengths. According to the ODG, chronic pain can have a mixed physiologic etiology of both that may be used to manage both acute and chronic pain. These medications are generally classified according to potency and duration of dosage. 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 Oxycodone is not medically necessary.

Oxycontin 60mg, #90 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the 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. Oxycontin (Oxycodone ER) 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 insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. In addition, the MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no discussion of functional status, appropriate medication use, or side effects. There is a lack of functional improvement with the treatment already provided. The treating physician did not provide sufficient evidence of improvement in the work status, activities of daily living, and dependency on continued medical care. In addition, the current combined MED is > 120, which is in excess of the guideline recommendations. Medical necessity for the requested medication was not established. This does not imply that some form of analgesia is contraindicated; only that the opioids as prescribed have not been prescribed according to the MTUS and that the results of use did not meet the requirements of the MTUS. This requested medication was not medically necessary.

Soma 350mg, #120 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Carisoprodol (Soma), Muscle relaxants (for pain).

Decision rationale: The CA MTUS does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. Soma (Carisoprodol) is the muscle relaxant requested in this case. This medication is sedating. No reports show any specific and significant improvements in pain or function as a result of prescribing muscle relaxants. According to the MTUS guidelines, Soma is categorically not recommended for chronic pain, noting its habituating and abuse potential. The guidelines also indicate that the effectiveness of muscle relaxants appear to diminish over time and prolonged use of the some medications in this class may lead to dependence. In this case, the

documentation shows that the injured worker has been prescribed this medication since at least 2014. The current request does not meet guideline recommendations. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.