

<b>Case Number:</b>	CM15-0031939		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	08/12/2009
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	01/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2015

### 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, Tennessee  
 Certification(s)/Specialty: Emergency 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 55-year-old male with an industrial injury date of 08/12/2009. The mechanism of injury is documented as a lumbar injury lifting a compressor out of a van while at work. He presented on 01/02/2015 for follow up. Tenderness to palpation of the lumbar spine was noted. Seated straight leg raise was negative bilaterally. Sensation in the lower extremities was intact. Prior treatments include physical therapy, back brace, lumbar fusion, chiropractic care, facet injections, lumbar epidural injection, medications and rhizotomy. Diagnoses: Lumbar degenerative disc disease, status post lumbar 4-sacral 1 fusion. Chronic low back pain, rule out right lumbar 5 radiculopathy. Bilateral sciatic pain. Pain related insomnia. History of Wolff-Parkinson-White syndrome, status posts multiple cardiac ablations. On 01/31/2015 utilization review issued the following decision: The request for Ambien 10 mg # 30 was modified to Ambien 10 mg # 15. ODG was cited. The request for MS Contin 100 mg was non-certified. MTUS and ODG were cited. The request for Oxycodone 30 mg #210 was non-certified. MTUS was cited. The request for Dss sodium 250 mg # 60 was non-certified. The request for Prilosec 20 mg # 30 was non-certified. MTUS was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10 mg #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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain, zolpidem.

**Decision rationale:** Zolpidem is a prescription short-acting nonbenzodiazepine 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. Cognitive behavioral therapy (CBT) should be an important part of an insomnia treatment plan. A study of patients with persistent insomnia found that the addition of zolpidem immediate release to CBT was modestly beneficial during acute (first 6 weeks) therapy, but better long-term outcomes were achieved when zolpidem IR was discontinued and maintenance CBT continued. Zolpidem is linked to a sharp increase in ED visits, so it should be used safely for only a short period of time. In this case the patient has been taking Ambien since at least July 2013. The duration of treatment surpasses the recommended short-term duration of two to six weeks. The request should not be authorized.

**MS Contin 100 mg:** 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).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 74-96.

**Decision rationale:** MS Contin is an extended release preparation of the opioid morphine. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain or function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDs have failed. In this case the patient has been receiving MS Contin since at least September 2012 and has not obtained analgesia. In addition there is no documentation that the patient has signed an opioid contract. Criteria for long-term opioid use have not been met. The request should not be authorized.

**Oxycodone 30 mg #210:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 74-96.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDS have failed. In this case the patient has been receiving oxycodone since at least September 2012 and has not obtained analgesia. In addition there is no documentation that the patient has signed an opioid contract. Criteria for long-term opioid use have not been met. The request should not be authorized.

**DSS Sodium 250 mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs for Irritable Bowel Syndrome Treatment Guidelines from The Medical Letter - July 1, 2011 Official Disability Guidelines: Pain Opioid-induced constipation treatment.

**Decision rationale:** DSS sodium is docusate, a stool softener. It works by increasing the amount of water that is absorbed by the stool in the gut. Opioid-induced constipation is a common adverse effect of long-term opioid use because the binding of opioids to peripheral opioid receptors in the gastrointestinal (GI) tract results in absorption of electrolytes, such as chloride, with a subsequent reduction in small intestinal fluid. Activation of enteric opioid receptors also results in abnormal GI motility. Constipation occurs commonly in patients receiving opioids and can be severe enough to cause discontinuation of therapy. If prescribing opioids has been determined to be appropriate, then ODG recommend that prophylactic treatment of constipation should be initiated. First-line: When prescribing an opioid, and especially if it will be needed for more than a few days, there should be an open discussion with the patient that this medication may be constipating, and the first steps should be identified to correct this. Simple treatments include increasing physical activity, maintaining appropriate hydration by drinking enough water, and advising the patient to follow a proper diet, rich in fiber. These can reduce the chance and severity of opioid-induced constipation and constipation in general. In addition, some laxatives may help to stimulate gastric motility. Other over-the-counter medications can help loosen otherwise hard stools, add bulk, and increase water content

of the stool. Second-line: If the first-line treatments do not work, there are other second-line options. About 20% of patients on opioids develop constipation, and some of the traditional constipation medications don't work as well with these patients, because the problem is not from the gastrointestinal tract but from the central nervous system, so treating these patients is different from treating a traditional patient with constipation. In this case the patient is experiencing opioid induced constipation. Constipation is side effect of non-authorized medication. The request should not be authorized.

**Prilosec 20 mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 68.

**Decision rationale:** Prilosec is omeprazole, a proton pump inhibitor (PPI). PPI's are used in the treatment of peptic ulcer disease and may be prescribed in patients who are using non-steroidal anti-inflammatory drugs and are at high risk for gastrointestinal events. Risk factors for high-risk events are age greater than 65, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The patient in this case was using NSAID medication and did not have any of the risk factors for a gastrointestinal event. The request should not be authorized.

**Motrin 600 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 67-68.

**Decision rationale:** Motrin is ibuprofen, a nonsteroidal anti-inflammatory drug (NSAID). Chronic Medical Treatment Guidelines state that "anti-inflammatory drugs are the traditional first line of treatment, but long term use may not be warranted." For osteoarthritis it was recommended that the lowest dose for the shortest length of time be used. It was not shown to be more effective than acetaminophen, and had more adverse side effects. Adverse effects for GI toxicity and renal function have been reported. Medications for chronic pain usually provide temporary relief. Medications should be prescribed only one at a time and should show effect within 1-3 days. Record of pain and function with the medication should be documented. In this case the patient had been receiving Motrin since at least September 2013 without relief. The duration of treatment increases the risk of adverse effects with little benefit. The request should not be authorized.