

Case Number:	CM14-0147545		
Date Assigned:	09/15/2014	Date of Injury:	07/14/2009
Decision Date:	10/17/2014	UR Denial Date:	08/15/2014
Priority:	Standard	Application Received:	09/11/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 52-year-old male who reported an injury on 07/14/2009. The mechanism of injury was not submitted for review. The injured worker diagnoses were status post right knee arthroscopy, valgus deformity of the right lower extremity, low back pain due to central disc protrusion at L4-5, and acute MI. Past medical treatment consists of surgery, the use of a TENS unit, physical therapy, and medication therapy. Medications include Duragesic patch, Ambien, Lidoderm patch, Colace, aspirin, Nitro stat, metoprolol, Plavix and Lisinopril. In 09/2012 the injured worker underwent an MRI of the lumbar spine, and in 03/2011 the injured worker underwent an MRI of the right knee. On 06/03/2014 the injured worker complained of knee and low back pain. The physical examination noted that the injured worker had a pain rate from 2/10 to 3/10 with medication and 8/10 to 9/10 without. Physical examination also revealed that the injured worker had weakness in the legs. He had diminished range of motion of the lumbar spine. The medical treatment plan was for the injured worker to continue the use of medication therapy. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro: Duragesic patch 50mcg #30: for a two month supply (dispensed 7/29/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl), ongoing management , opioid dosing Page(s): 44, 78, 86.

Decision rationale: The request for Retro: Duragesic patch 50mcg #30: for a two month supply (dispensed 7/29/14) was not medically necessary. The California MTUS Guidelines indicate that Duragesic patches are not recommended as first line therapy. The FDA approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the patient is being monitored for aberrant drug behavior and side effects. The cumulative dosing of all opioids should not exceed 120 mg oral morphine equivalence per day. The submitted documentation did not indicate that the injured worker had trialed and failed any first line therapy. Additionally, there was no documentation of objective improvement in function, objective decrease in pain, and evidence that the injured worker had been monitored for aberrant drug behavior. Furthermore, there was no mention of any side effects the injured worker might have had. Given the above, the injured worker was not within the MTUS recommended guidelines. As such, the request for Retro: Duragesic patch 50mcg #30: for a two month supply (dispensed 7/29/14) was not medically necessary.

Retro: Ambien10mg daily #60: for a two month supply (dispensed 7/29/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Insomnia Treatment

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

Decision rationale: The request for Retro: Ambien10mg daily #60: for a two month supply (dispensed 7/29/14) was not medically necessary. The Official Disability Guidelines state that Ambien is a prescription short acting nonbenzodiazepine hypnotic, which is approved for short term therapy, usually 2 to 6 weeks, for treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain, and is often hard to obtain. Various medications may provide short term benefit. While sleeping pills, so called minor tranquilizers, and antianxiety agents are commonly prescribed for 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 in the long term. Cognitive behavioral therapy should be an important part of an insomnia treatment plan. The request for Ambien 10 mg with a quantity of 60 would translate to a 2 month supply of medication, and would exceed the guideline recommendations of short term use. Additionally, documentation dated 12/11/2013 indicates that the injured worker had been on this medication since at least this time, exceeding the recommended guidelines for short term therapy. Given the above, the injured worker is not within the Official Disability Guidelines recommended criteria. As such, the request was not medically necessary.

Retro: colace 100mg four times per day #26 for a to month supply (dispensed 7/29/14):
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) Pain, Opioid-induced constipation treatment (Docusate).

Decision rationale: The request for Retro: Colace 100mg four times per day #26 for a two month supply (dispensed 7/29/14) is not medically necessary. The Official Disability Guidelines recommend opioid induced constipation treatment. Upon prescribing an opioid, especially if it will be needed for more than a few days, there should be an open discussion with the injured worker that this medication may be constipating, and the first step should be to identify and correct it. Simple treatment teachings such as including increasing physical therapy, maintaining hydration by drinking enough water, and advising the injured worker to follow a proper diet rich in fiber, can reduce the chance and severity of opioid induced constipation and constipation in general. In addition, some laxatives may be helpful to stimulate gastric motility. Other over the counter medications can help loosen otherwise hard stools and bulk, and increase water content of stool. There was no indication in the submitted report that the provider had educated the injured worker on proper hydration, proper diet and proper exercise regarding opioid induced constipation. Furthermore, the submitted documentation did not indicate that the injured worker had complaints of constipation. Given the above, the medical necessity of Colace is unclear. As such, the request is not medically necessary.