

<b>Case Number:</b>	CM14-0107465		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	02/12/2003
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	07/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2014

### 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. 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: Pediatrics, Internal 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 34 year old male, who sustained an industrial injury on 02/12/2003. He has reported subsequent elbow and wrist pain and was diagnosed with Panner's syndrome status post multiple interventions to the elbow and mild wrist joint inflammation due to radioulnar joint dysfunction. Treatment to date has included oral pain medication and surgery. In a progress note dated 06/18/2014, the injured worker complained of severe pain and vomiting blood with Oxycodone. The physician noted that the injured worker would have to see a pain specialist before the dosage could be changed. Objective findings were notable for limited range of motion of the right elbow. A request for authorization of Oxycodone, Colace, Lunesta and Xanax refills was made.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**COLACE 250MG #30:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioid-induced constipation treatment and Other Medical Treatment Guidelines uptodate.com.

**Decision rationale:** MTUS does not comment on laxative use in chronic pain. ODG guidelines recommended as indicated below. In the section, Opioids, criteria for use, if prescribing opioids has been determined to be appropriate, then ODG recommends, under Initiating Therapy, that Prophylactic treatment of constipation should be initiated. First line treatment includes 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. There are no notations of failure of first line treatments or constipation in the records provided. This request is not medically necessary and appropriate. Colace is indicated for use as a stool softener. The IW may have hard stools or constipation due to use of narcotics however there was no notation in the progress notes. The request is not medically necessary and appropriate.

**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, INSOMNIA.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Insomnia treatment.

**Decision rationale:** Per ODG pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). First-line treatment is recommended to be non-benzodiazepine sedative-hypnotics such as Ambien, Ambien CR, Sonata and Lunesta. Sedating antidepressants (e.g., amitriptyline, trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia (Buscemi, 2007) (Morin, 2007), but they may be an option in patients with coexisting depression. There was no mention in the case file of evaluation for insomnia or failure of first line treatment options. This request is not medically necessary and appropriate.

**OXYCODONE 30 MG # 180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; 4) On-Going Management; 6) When to Discontinue Opioids; 7) When to Continue Opioids for chronic pain Page(s): 78-80.

**Decision rationale:** The IW has been on long term opioids which is not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary and appropriate.

**OXYCODONE 80 MG # 120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; 4) On-Going Management; 6) When to Discontinue Opioids; 7) When to Continue Opioids for chronic pain Page(s): 78-80.

**Decision rationale:** The IW has been on long term opioids which is not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. This request is not medically necessary and appropriate.

**XANAX 1 MG # 120:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** According to MTUS guidelines benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. According to the progress notes the IW has been using benzodiazepines for a prolonged time. This request is not medically necessary and appropriate