

Case Number:	CM14-0210294		
Date Assigned:	12/23/2014	Date of Injury:	02/24/2012
Decision Date:	02/20/2015	UR Denial Date:	11/10/2014
Priority:	Standard	Application Received:	12/15/2014

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 Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 patient is a 42-year-old man who sustained a work related injury on February 24, 2012. Subsequently, he developed chronic low back pain. According to a progress report dated October 6, 2014, the patient reported ongoing pain in his upper and lower back. It has been recommended evaluation by urologist due to patient's sexual dysfunction, but this has not yet been authorized. On examination, the thoracolumbar spine was focally tender. He had difficulty with sitting for prolonged periods. Neurologically, he did have weakness in his lower extremities. X-rays of the thoracic spine and lumbar spine showed incomplete fusion at the thoracolumbar junction. The patient was diagnosed with cervical sprain/strain, status post transthoracic fusion/discectomy followed by posterior fusion T11-T12, status post L4 through S1 laminectomy, discectomy, and foraminotomies, persistent and significant pain syndrome, depression, stress, and anxiety. The provider requested authorization for Neurontin, Docusate, Percocet, and Restoril.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 300mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
 Page(s): 49,.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49.

Decision rationale: According to MTUS, Neurontin has been shown to be effective for the treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered to be first line treatment for neuropathic pain. Continuous use of Neurontin cannot be certified without documentation of efficacy. Therefore the request for Neurontin 300mg is not medically necessary.

Docusate 50mg, #60: 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) Opioid induced constipation treatment. (<http://worklossdatainstitute.verioiponly.com/odgtwc/pain.htm#Opioidinducedconstipationtreatment>).

Decision rationale: According to ODG guidelines, docusate/sennosides is recommended as a second line treatment for opioid induced constipation. The first line measures are increasing physical activity, maintaining appropriate hydration, advising the patient to follow a diet rich in fiber, using some laxatives to stimulate gastric motility, and use of some other over the counter medications. It is not clear from the patient file that the patient developed constipation or that first line measurements were used. Therefore the use of Docusate 50mg is not medically necessary.

Percocet 10/325mg, #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

Decision rationale: According to MTUS guidelines, ongoing use of opioids should follow specific rules:(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing 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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing

Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. The patient has been using opioids for long time without recent documentation of full control of pain and without any documentation of functional or quality of life improvement. There is no clear documentation of patient improvement in level of function, quality of life, adequate follow up for absence of side effects and aberrant behavior with a previous use of narcotics. Therefore the prescription of Percocet 10/325mg, #150 is not medically necessary.

Restoril 30mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Page(s): 24.

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

Decision rationale: According to ODG Guidelines and in the treatment of insomnia section Recommends that treatment be based on the etiology, with the medications recommended below. See Insomnia. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. (Lexi-Comp, 2008) Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning. Pharmacologic Treatment: There are four main categories of pharmacologic treatment: (1) Benzodiazepines; (2) Non-benzodiazepines; (3) Melatonin & melatonin receptor agonists; & (4) Over-the-counter medications. The majority of studies have only evaluated short-term treatment (i.e., 4 weeks) of insomnia; therefore more studies are necessary to evaluate the efficacy and safety of treatments for long-term treatment of insomnia. In 2007, the FDA requested that manufacturers of all sedative-hypnotic drugs strengthen product labeling regarding risks (i.e., severe allergic reactions and complex sleep-related behaviors, such as sleep driving). It is recommended that treatments for insomnia should reduce time to sleep onset, improve sleep maintenance, avoid residual effects and increase next-day functioning. (Morin, 2007) (Reeder, 2007) (1) Benzodiazepines: FDA-approved benzodiazepines for sleep maintenance insomnia include estazolam (ProSom), flurazepam (Dalmane), quazepam (Doral), and temazepam (Restoril). Triazolam (Halcion) is FDA-approved for sleep-onset insomnia. These medications are only recommended for short-term use due to risk of tolerance, dependence, and adverse events (daytime drowsiness, anterograde amnesia, next-day sedation, impaired cognition, impaired psychomotor function, and rebound insomnia). These drugs have been associated with sleep-related activities such as sleep driving, cooking and eating food, and making phone calls (all while asleep). Particular concern is noted for patients at risk for abuse or addiction. Withdrawal occurs with abrupt discontinuation or large decreases in dose. Decrease slowly and monitor for withdrawal symptoms.

Benzodiazepines are similar in efficacy to benzodiazepine-receptor agonists; however, the less desirable side-effect profile limits their use as a first-line agent, particularly for long-term use. According to MTUS guidelines, benzodiazepines are not recommended for long term use for pain management because of unproven long term efficacy and because of the risk of dependence. Most guidelines limit their use to 4 weeks. There is no recent documentation of insomnia related to pain. Therefore the prescription of Restoril 30mg, #30 is not medically necessary.