

Case Number:	CM14-0217371		
Date Assigned:	01/07/2015	Date of Injury:	01/26/2009
Decision Date:	03/04/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	12/29/2014

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, 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 patient is a 53-year-old male who was injured on January 26, 2009. The patient continued to experience pain in his neck and upper extremities. Physical examination was notable for decreased range of motion of the cervical spine, left upper extremity muscular atrophy, weakness of the left upper extremity, and decreased sensation of both hands. Diagnoses included multilevel cervical degenerative disc disease, bilateral upper extremity radiculopathy, bilateral carpal tunnel syndrome, and left cubital syndrome. Treatment included medications, Botox injections, surgery, and physical therapy. Requests for authorization for Morphine Sulfate ER increase from 15 mg to 30 mg, ambien, omeprazole, and KGL cream were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

Increase Morphine sulfate ER from 15mg to 30mg: 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): 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 had been taking Morphine ER 15 mg 3 times daily with Morphine IR 15 mg for breakthrough pain and achieving adequate analgesia. Temporary increase in long acting pain medication was requested when the patient experienced pain from pancreatitis. Increase in a short duration of increased pain should be managed on an as needed basis with shorter-acting analgesics. Doubling the dose of a long-acting opioid preparation increases the risk of adverse effects, such as lethargy, dependence, and respiratory depression. Medical necessity for increasing the dose of Morphine ER has not been established. The request should not be authorized.

Ambien: 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), Zolpidem (Ambien)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain, Zolpidem

Decision rationale: Ambien is the sleep medication, zolpidem. 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 the Ambien since at least May 2014. The duration of treatment surpasses the recommended maximum of two to six weeks and increased the risk of adverse effects. The request should not be authorized.

Omeprazole: 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): 68.

Decision rationale: Omeprazole is 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 not using NSAID medication and did not have any of the risk factors for a gastrointestinal event. The request should not be authorized.

KGL cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 111-112.

Decision rationale: KGL cream is a topical analgesic containing ketoprofen, gabapentin, and lidocaine. Topical analgesics are recommended for neuropathic pain when anticonvulsants and antidepressants have failed. Compounded topical analgesics are commonly prescribed and there is little to no research to support the use of these compounds. Furthermore, the guidelines state that "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Absorption of the drug depends on the base it is delivered in. Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. It is not recommended, Gabapentin is not recommended. There is no peer-reviewed literature to its support use. Lidocaine is recommended for localized peripheral pain after the evidence of a trial for first-line therapy, such as an antidepressant or antiepileptic drug. It is only FDA approved for the treatment of post-herpetic neuralgia. The guidelines state that further research is needed to recommend this treatment for chronic neuropathic pain. In this case the patient is not suffering from postherpetic neuralgia. Lidocaine is not recommended. This medication contains drugs that are not recommended. Therefore the medication cannot be recommended. The request should not be authorized.