

Case Number:	CM15-0123357		
Date Assigned:	07/07/2015	Date of Injury:	09/21/1999
Decision Date:	08/18/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	06/26/2015

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: California
 Certification(s)/Specialty: Family Practice

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 57 year old female, who sustained an industrial injury on September 21, 1999. Treatment to date has included diagnostic imaging of the right shoulder, lumbar spine, cervical spine, and hip, medications, orthotics, and home exercise. Currently, the injured worker complains of chronic low back pain, right leg pain, bilateral shoulder pain, neck pain with radiation of pain to the bilateral shoulder and hand, and chronic knee pain. She reports no changes in her low back, hand, shoulder and neck pain. She reports an increased numbness in the bilateral hands and fingers. She has a burning sensation at the mid back into the buttocks when lying on her back. A soft back brace helps to alleviate the pain. Her sleep quality is fair with Lunesta and she average four hours of sleep. The injured worker rates her average pain an 8 on a 10-point scale and her functional level a 7 on a 10-point scale. On physical examination, the injured worker has residual ongoing low back pain with radiation of pain to the bilateral lower extremities. She has bilateral shoulder pain. Her pain is worse with sitting and with activity. She uses a cane for ambulation. The diagnoses associated with the request include degenerative lumbar disc disease, cervical spondylosis without myelopathy, lumbago, displacement of the lumbar disc without myelopathy, cervicgia, lumbosacral spondylosis without myelopathy, unspecified myalgia and myositis, cervicocranial syndrome and sacroilitis. The treatment plan includes continued MS Contin, Percocet, Cymbalta, and Lunesta, continued home exercise program and right lumbar medial branch block.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg QID PRN #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 80.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the long-term use of opioids, including Percocet. These guidelines have established criteria on the use of opioids for the ongoing management of pain. Actions should include: prescriptions from a single practitioner and from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. There should be an 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. There should be evidence of documentation of the "4 A's for Ongoing Monitoring." These four domains include: pain relief, side effects, physical and psychological functioning, and the occurrence of any potentially aberrant drug-related behaviors. Further, there should be consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain that does not improve on opioids in 3 months. There should be consideration of an addiction medicine consult if there is evidence of substance misuse (Pages 76-78). Finally, the guidelines indicate that for chronic back pain, the long-term efficacy of opioids is unclear. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy (Page 80). Based on the review of the medical records, there is insufficient documentation in support of these stated MTUS/Chronic Pain Medical Treatment Guidelines for the ongoing use of opioids. It was noted in the records that on 12/8/2014 the patient's urine drug screen was positive for fentanyl, temazepam and oxazepam; despite not being prescribed. This is consistent with aberrant behavior. Use of non-prescribed opioids and benzodiazepines by the patient is not consistent with the above cited requirements for long-term use of opioids. The medical records indicate that this concern was going to be addressed at the next visit; however, there is no evidence in the medical records provided that this was done. For this reason, continued use of Percocet is not medically necessary.

MS Contin 60mg q12 hours PRN #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 80.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the long-term use of opioids, including MS Contin. These guidelines have established criteria on the use of opioids for the ongoing management of pain. Actions should include: prescriptions from a single practitioner and from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. There should be an 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. There should be evidence of documentation of the "4 A's for Ongoing Monitoring." These four domains include: pain relief, side effects, physical and psychological functioning, and the occurrence of any potentially aberrant drug-related behaviors. Further, there should be consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain that does not improve on opioids in 3 months. There should be consideration of an addiction medicine consult if there is evidence of substance misuse (Pages 76-78). Finally, the guidelines indicate that for chronic back pain, the long-term efficacy of opioids is unclear. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy (Page 80). Based on the review of the medical records, there is insufficient documentation in support of these stated MTUS/Chronic Pain Medical Treatment Guidelines for the ongoing use of opioids. It was noted in the records that on 12/8/2014 the patient's urine drug screen was positive for fentanyl, temazepam and oxazepam; despite not being prescribed. This is consistent with aberrant behavior. Use of non-prescribed opioids and benzodiazepines by the patient is not consistent with the above cited requirements for long-term use of opioids. The medical records indicate that this concern was going to be addressed at the next visit; however, there is no evidence in the medical records provided that this was done. For this reason, continued use of MS Contin is not medically necessary.

Lunesta 2mg 1 PO QHS PRN #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain (updated 04/30/15) 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) Chapter: Pain/ChronicSection: Eszopiclone.

Decision rationale: The Official Disability Guidelines comments on the use of Lunesta (eszopiclone) as a treatment for insomnia. Lunesta is not recommended for long-term use, but recommended for short-term use. Recommend limiting use of hypnotics to three weeks maximum in the first two months of injury only, and discourage use in the chronic phase. 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. In this study, eszopiclone (Lunesta) had a Hazard ratio for death of 30.62 (C.I., 12.90 to 72.72), compared to zolpidem at 4.82 (4.06 to 5.74). In general, receiving hypnotic prescriptions was associated with greater than a threefold increased hazard of death even when prescribed less than 18 pills/year. (Kripke, 2012) The FDA has lowered the recommended starting dose of eszopiclone (Lunesta) from 2 mg to 1 mg for both men and women. Previously recommended doses can cause impairment to driving skills, memory, and coordination as long as 11 hours after the drug is taken. Despite these long-lasting effects, patients were often unaware they were impaired. (FDA, 2014) The records indicate that Lunesta is being used as a long-term treatment strategy for this patient's insomnia. As noted in the above cited guidelines, only short-term use is recommended. Therefore, Lunesta is not medically necessary.

Cymbalta 60mg BID #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-16.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of antidepressants, including Cymbalta, as a treatment modality. Antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. (Additional side effects are listed below for each specific drug.) It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. Regarding Cymbalta, the MTUS guidelines state the following: Duloxetine (Cymbalta): FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. Used off-label for neuropathic pain and radiculopathy. Duloxetine is recommended as a first-line option for diabetic neuropathy. No high quality evidence is reported to support the use of duloxetine for lumbar radiculopathy. More studies are needed to determine the efficacy of duloxetine for other types of neuropathic pain. In this case, there is insufficient documentation on the effectiveness of Cymbalta as a treatment modality. It is unclear when Cymbalta was initiated and whether outcome measurements have been done. The medical records suggest that there has not been a substantive impact of Cymbalta on the quality of the patient's sleep or changes in the use of other medications. Without this information, Cymbalta is not considered as medically necessary.