

Case Number:	CM15-0171489		
Date Assigned:	09/11/2015	Date of Injury:	07/08/2011
Decision Date:	10/09/2015	UR Denial Date:	08/03/2015
Priority:	Standard	Application Received:	08/31/2015

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: North Carolina

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 35 year old female who sustained an industrial injury on July 08, 2011. A primary treating progress note dated February 12, 2015 reported the worker with subjective complaint of continued symptoms of the left knee which is usually aggravated by the end of her work day. The pain is currently managed with "Lidoderm patches, use of a brace and as needed Dilaudid at times for severe knee pain." Objective assessment found the worker with normal gait; without effusion, and at this point with full range of motion zero to 125 degrees in flexion. She is status post right knee arthroscopy with partial medial meniscectomy. The assessment noted the worker with "moderate osteoarthritis of the patellofemoral and medial compartment status post abrasion chondroplasty for grade IV chondral changes". She is to follow up in three months for re-evaluation; send brace back within allotted time frame and if a flare up arises that is not able to be managed with current medication regimen, then she is to come in sooner than scheduled visit for a planned steroid injection. At primary follow up dated March 03, 2015 she had noted subjective complaint of left knee pain rated a 3 in intensity out of 10 with the use of medications; pain is rated a 5 in intensity out of 10 without the use of medications. She states she does not take medications at work only uses the Lidoderm patches which offer significant pain coverage during the work hours, "allowing her to function". Her quality of sleep is rated as "good" getting 7-8 hours of sleep on average nightly. Current medication regimen consisted of: Lidoderm patches, Dilaudid 2mg, and Lunesta. The following medications were noted as trialed: Norco, Ultracet, oxycodone, Rozerem, Gabapentin, Hydrocodone, Tramadol, Nucynta, and Cymbalta. The treating diagnoses were: knee pain and pain in joint lower leg. The following were

prescribed this visit: Lidoderm patches 5%, and Dilaudid 2mg. A primary treating follow up dated July 22, 2015 reported current medication regimen consisted of: Lidoderm patches, Dilaudid, Lunesta, and Terocin patches. The following medications were prescribed this visit: Ambien 5mg, and Dilaudid.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 5mg, #25: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG), ODG-TWC Pain Procedure Summary.

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

Decision rationale: The California MTUS and the ACOEM do not specifically address this medication. Per the official disability guidelines recommend pharmacological agents for insomnia only is used after careful evaluation of potential causes of sleep disturbance. Primary insomnia is usually addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. Pharmacological treatment consists of four main categories: Benzodiazepines, Non-benzodiazepines, Melatonin and melatonin receptor agonists and over the counter medications. Sedating antidepressants have also been used to treat insomnia however, there is less evidence to support their use for insomnia, but they may be an option in patients with coexisting depression. The patient does not have the diagnosis of primary insomnia or depression. There is also no documentation of first line insomnia treatment options such as sleep hygiene measures. Therefore, the request is not medically necessary.

Dilaudid 2mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (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 for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) 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 does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids (a) If the patient has returned to work (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox- AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is documented significant decrease in objective pain measures such as VAS scores for significant periods of time. There are no objective measures of improvement of function. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.