

<b>Case Number:</b>	CM13-0007778		
<b>Date Assigned:</b>	03/03/2014	<b>Date of Injury:</b>	10/11/2003
<b>Decision Date:</b>	04/24/2014	<b>UR Denial Date:</b>	07/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/05/2013

### 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. The expert reviewer is Board Certified in Preventative Medicine, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 43-year-old female with a 10/11/03 date of injury. Subjective complaints include low back pain radiating down the right lower extremity and poor sleep quality. Objective findings include restricted lumbar range of motion, tenderness to palpation of the lumbar spine as well as spasms, positive facet loading, and weakness in the bilateral lower extremities. Current diagnoses include chronic pain syndrome, hip pain, low back pain, lumbar disc degeneration, and insomnia, and treatment to date has been Atarax, Percocet, and Zanaflex since at least 1/30/12 with optimized function and activities of daily living. In addition, the 7/23/13 medical report identifies that the patient has signed a pain contract. Furthermore, 7/23/13 medical report plan identifies Atarax for pruritus caused by the patient's opioid pain medications, and trial of Ambien to address the patient's insomnia.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**AMBIEN CR 12.5MG #20:** 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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**Decision rationale:** Guidelines state that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions, an increase in activity tolerance, and/or a reduction in the use of medications or medical services. The Official Disability Guidelines state that Ambien is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. The ODG also states that the dose should be lowered from from 12.5mg to 6.25mg for ER products (Ambien CR) when prescribed to women. Within the medical information available for review, there is documentation of a diagnosis of insomnia. However, despite documentation of a plan identifying trial of Ambien, there is no documentation of the intended duration of therapy. In addition, given documentation of the request for Ambien CR12.5mg, there is no documentation that the dose has been lowered. Therefore, based on guidelines and a review of the evidence, the request for Ambien is not medically necessary.

**ZANAFLEX 4MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines identify documentation of spasticity as criteria necessary to support the medical necessity of Zanaflex. In addition, the MTUS identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions, an increase in activity tolerance, and/or a reduction in the use of medications or medical services. The Official Disability Guidelines identify that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of chronic pain syndrome, hip pain, low back pain, and lumbar disc degeneration. In addition, given documentation of ongoing treatment with Zanaflex since at least 1/30/12 with optimized function and activities of daily living, there is documentation of functional benefit or improvement as an increase in activity tolerance as a result of use of Zanaflex. Furthermore, there is documentation of muscle spasms. However, given documentation of a 10/11/03 date of injury, there is no documentation of acute muscle spasms. In addition, given documentation of ongoing treatment with Zanaflex since at least 7/17/02, there is no documentation of the intention to treat over a short course (less than two weeks). Therefore, based on guidelines and a review of the evidence, the request for Zanaflex is not medically necessary.

**ATARAX 25MG #60:** 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 California Code of Regulations, and Drugs.com

**Decision rationale:** Medical Treatment Guideline identifies documentation of anxiety, tension, or pruritis due to allergic conditions as criteria necessary to support the medical necessity of Atarax. Guidelines state that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions, an increase in activity tolerance, and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of chronic pain syndrome, hip pain, low back pain, and lumbar disc degeneration. In addition, given documentation of ongoing treatment with Atarax since at least 1/30/12 with optimized function and activities of daily living, there is documentation of functional benefit or improvement as an increase in activity tolerance as a result of use of Atarax. However, despite documentation of a plan identifying Atarax for pruritus caused by the patient's opioid pain medications, there is no documentation of pruritus due to allergic conditions, such as chronic urticaria and atopic and contact dermatoses, and histamine-mediated pruritus. Therefore, based on guidelines and a review of the evidence, the request for Atarax is not medically necessary.

**150 PERCOCET 10/325MG:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-80.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that opioids may be recommended with documentation that opioid prescriptions are from a single practitioner and are taken as directed, that the lowest possible dose is being prescribed, and that there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Guidelines state that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions, an increase in activity tolerance, and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of chronic pain syndrome, hip pain, low back pain, and lumbar disc degeneration. In addition, given documentation of a pain contract, there is documentation that the prescriptions are from a single practitioner and are taken as directed, the lowest possible dose is being prescribed, and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Furthermore, given documentation of ongoing treatment with Percocet since at least 1/30/12 with optimized function and activities of daily living, there is documentation of functional benefit and improvement as an increase in activity tolerance as a result of use of Percocet. Therefore, based on guidelines and a review of the evidence, the request for Percocet is medically necessary.