

<b>Case Number:</b>	CM13-0011683		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	07/14/2008
<b>Decision Date:</b>	03/11/2014	<b>UR Denial Date:</b>	07/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/15/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Neurology, has a subspecialty in Neuromuscular 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 physician 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:

This patient sustained a work related injury on July 14 2008. She subsequently developed chronic neck pain and left shoulder pain. According to the progress note of June 6 2013, the patient was reported to have severe neck pain. Physical examination showed cervical tenderness with reduced range of motion and positive Spurling's test. The patient was treated with physical therapy, medications, acupuncture, cervical surgery and cervical epidural injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Orudis:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines section on NSAIDS Page(s): 67-68.

**Decision rationale:** Orudis is a non steroid anti-inflammatory drug (NSAID). According to the MTUS Chronic Pain Guidelines, Orudis is recommended for osteoarthritis pain at the lowest dose and for the shortest period of time for patients with moderate to severe pain. It is also recommended as a second line therapy after acetaminophen in case of acute exacerbations of chronic back pain or in chronic back pain for short period of time. The medical records provided

for review did not offer much information about the rationale to use Orudis for this patient. Therefore the prescription of Orudis is not medically necessary and appropriate.

**Retro Zanaflex:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines section on Muscle relaxants Page(s): 63.

**Decision rationale:** According to the MTUS Chronic Pain Guidelines, Zanaflex, a non sedating muscle relaxants, is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient in this case does not have clear exacerbation of his back pain and the prolonged use of Zanaflex is not justified. The request is not medically necessary.

**Retro Prilosec:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines section on NSAIDS Page(s): 68.

**Decision rationale:** According to the MTUS Chronic Pain Guidelines, Prilosec as well as other proton pump inhibitors are indicated when NSAID are used in patients with intermediate or high risk for gastrointestinal events. There is no documentation in the medical records provided for review that he is at intermediate or high risk for developing gastrointestinal events. Therefore, the request for Prilosec is not medically necessary and appropriate.

**Retro Norco:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines section on Opioids Page(s): 76-79.

**Decision rationale:** According to the MTUS Chronic Pain Guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but is not recommended as a first line oral analgesic. In addition and according to the MTUS Chronic Pain Guidelines, the ongoing use of opioids should follow specific rules, "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." There is no clear evidence of objective and recent functional and pain improvement with previous use of opioids (Norco). There no clear documentation of the efficacy/safety of previous use of Norco. There is no recent evidence of objective monitoring of compliance of the patient with his medications. There is no clear justification for the need to continue the use of Norco. Therefore, the prescription of Norco is not medically necessary at this time.

**Retro Ambien:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines section on Antidepressants Page(s): 14. Decision based on Non-MTUS Citation Official Disability Guidelines section on Insomnia Treatment.

**Decision rationale:** Ambien is a nonbenzodiazepine hypnotic agent that is a pyrrolopyrazine derivative of the cyclopyrrolone class. According to the MTUS Chronic Pain Guidelines, tricyclic antidepressants are recommended as a first line option in neuropathic pain, especially if pain is accompanied by insomnia, anxiety or depression. Ambien could be used as an option to treat insomnia. There is no clear documentation that the patient suffered from insomnia. Furthermore, there is no documentation of the use of non pharmacologic treatment for the patient's sleep issue if there is any. Therefore, the prescription of Ambien is not medically necessary

**Retro transdermal analgesic ointments:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines section on Topical Analgesics Page(s): 111.

**Decision rationale:** According to the MTUS Chronic Pain Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to the MTUS Guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no documentation of the ointment components. Therefore, the request is not medically necessary and appropriate.