

<b>Case Number:</b>	CM13-0013913		
<b>Date Assigned:</b>	03/10/2014	<b>Date of Injury:</b>	09/17/1993
<b>Decision Date:</b>	04/03/2014	<b>UR Denial Date:</b>	08/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2013

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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.

### 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 66-year-old male with a date of injury of 09/17/1993. The listed diagnoses per [REDACTED], dated 07/11/2013, are: (1) mood disorder; (2) low back pain; (3) spinal/lumbar DDD. According to report dated 07/11/2013 by [REDACTED], the patient presents with continued low back pain. It was noted that pain level has "increased since last visit." The treating physician goes on to note "patient's quality of sleep is poor; activity level has remained the same." Examination of the lumbar spine showed range of motion is restricted with flexion limited at 60 degrees and extension limited to 10 degrees on palpation. Vertebral muscle tenderness is noted on both the sides. Treater states patient is stable on current medication regimen and has not changed essential regimen in greater than six months. "Function and activities of daily living improved optimally on current doses of medication."

### IMR ISSUES, DECISIONS AND RATIONALES

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

**AMBIEN 10MG, #45:** 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

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

**Decision rationale:** The MTUS/ACOEM guidelines do not address Ambien. However, the Official Disability Guidelines (ODG) states that Zolpidem (Ambien) is indicated for short-term treatment of Final Determination Letter for IMR Case Number CM13-0013913 3 insomnia with difficulty of sleep, onset 7 to 10 days. In this case, medical records indicate that this patient has been prescribed Ambien since 01/24/2013. The Official Disability Guidelines (ODG) does not recommend long-term use of this medication. The request for Ambien 10mg, # 45 is not medically necessary and appropriate.

**DURAGESIC 75MCG/HR PATCH, #15:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 88-89.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines, states Duragesic (fentanyl transdermal system) is not recommended as a first-line therapy. Duragesic is the trade name of fentanyl transdermal therapeutic system which releases fentanyl, a potent opioid, slowly through the skin. Medical records indicate this patient has been utilizing Duragesic since 01/24/2013. For chronic opiate use, MTUS guidelines page 88 and 89 require functioning documentation using a numerical scale or validated instrument at least once every 6 months. Documentation of the 4 A's (analgesia, ADLs, adverse side effects, adverse behavior) are required. Furthermore, under Outcome Measured, it also recommends documentation of current pain, average pain, least pain, time it takes for medication to work, duration of pain with medication, etc. In this case, the treater provides a statement that "function in activities of daily living improved optimally on current doses of medication" in reports July, June, May, and April. These are repetitious statements without any specifics regarding the patient's function. Furthermore, no numerical scales are used to assess the patient's pain and function as required by MTUS. Reports from March and February simply states "medications are working well." These documentations are inadequate per MTUS requirements. The request for Duragesic 75mcg/hr Patch, #15 is not medically necessary and appropriate.

**PERCOCET 10/325MG, #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60-61.

**Decision rationale:** For chronic opiate use, MTUS Chronic Pain Medical Treatment Guidelines page 88 and 89 require functioning documentation using a numerical scale or validated instrument at least once every 6 months. Documentation of the 4 A's (analgesia, ADLs, adverse side effects, adverse behavior) are required. Furthermore, under Outcome Measured, it also recommends documentation of current pain, average pain, least pain, time it takes for medication

to work, duration of pain with medication, etc. In this case, the treater provides a statement that "function in activities of daily living improved optimally on current doses of medication" in reports July, June, May, and April. These are repetitious statements without any specifics regarding the patient's function. Furthermore, no numerical scales are used to assess the patient's pain and function as required by MTUS. Reports from March and February simply states "medications Final Determination Letter for IMR Case Number CM13-0013913 4 are working well." These documentations are inadequate per MTUS requirements. The request for Percocet 10/325mg, #180 is not medically necessary and appropriate.

**MEDROL 4MG DOSEPAK, #1: 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.

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

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines do not discuss use of Medrol pack. However, the Official Disability Guidelines (ODG) recommends "oral corticosteroids for limited circumstances as noted below for acute radicular pain, not recommended for acute non-radicular pain (i.e., axial pain) or chronic pain. Multiple severe adverse effects have been associated with systemic steroid use. This is more likely to occur after long-term use." Medical records indicate this patient was prescribed Medrol Dosepak on 06/13/2013 as a trial for patient's neuropathic pain. The patient was again prescribed this medication on 07/11/2013. Medrol Dosepaks are not recommended for chronic pain. This patient does not present with acute radiculopathy and suffers from chronic pain. The use of Medrol Dosepaks is not recommended in these patients. The request for Medrol 4mg Dosepak, #1 is not medically necessary and appropriate.