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| <b>Case Number:</b>   | CM13-0014468 |                              |            |
| <b>Date Assigned:</b> | 11/06/2013   | <b>Date of Injury:</b>       | 03/03/2000 |
| <b>Decision Date:</b> | 01/23/2014   | <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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California and Texas. 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:

The patient is a 66-year-old female who reported an injury on 03/03/2000. The mechanism of injury was not provided. The patient was noted to have low back pain that radiated to the right leg and foot and spasm on the left side of the back. The diagnosis was noted to include lumbar disc degeneration and displacement of lumbar intervertebral disc without myelopathy. The request was made for Soma 350mg #90, Ambien CR 12.5mg #30, and Percocet 10/325mg #240.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Soma 350mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 29, 65.

**Decision rationale:** The California MTUS states that Soma (Carisoprodol) is not indicated for longer than a 2 to 3 week period. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant. The clinical documentation submitted for review failed to provide the necessity for ongoing treatment with this drug. There was a lack of documentation of a thorough physical examination. It was noted that the patient could function with the current medical

regimen; however, there was a lack of documentation to indicate the efficacy of the requested medication. Given the above, the request for Soma 350mg #90 is not medically necessary.

**Ambien CR 12.5mg #30:**

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

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

**Decision rationale:** The Official Disability Guidelines indicate that Zolpidem is approved for the short-term (usually two to six weeks) treatment of insomnia. The clinical documentation submitted for review failed to provide the efficacy and the necessity of long-term treatment with the requested medication. Additionally, it failed to indicate if the patient had tried and failed lower levels of treatment. Given the above, the request for Ambien CR 12.5mg #30 is not medically necessary.

**Percocet 10/325mg #240: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 88-89, 93.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, ongoing management Page(s): s 75, 78.

**Decision rationale:** The California MTUS guidelines recommend oxycodone/acetaminophen (Percocet) for moderate to severe chronic pain. There should be documentation of the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. The clinical documentation indicates the patient is stable on the current medication regimen and has been able to maintain function, especially with activities of daily living. It was noted the patient was able to function at a higher level than if they were off the current regimen. Without the current medical regimen, the patient would not be able to continue with their current activity level and the patient was noted to deny side effects or adverse reactions to the medications. However, the clinical documentation failed to provide efficacy of the requested medication, Percocet. Additionally, it failed to provide documentation of whether the patient has aberrant drug taking behavior. Given the above, the request for Percocet 10/325mg #240 is not medically necessary.