

<b>Case Number:</b>	CM13-0017548		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	06/12/2002
<b>Decision Date:</b>	01/23/2014	<b>UR Denial Date:</b>	08/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2013

### 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, 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 46-year-old who reported an injury on 06/12/2002. Per the documentation submitted for review, this patient has no stated side effects from her medications and overall is doing fairly well. The notes indicate that the patient's medication does not eliminate all of the pain; however, it is very helpful. The patient reported a pain level of 4/10 to 8/10 and indicated that she was starting to get relief from the epidural steroid injection that she received and felt as though she had achieved 30% improvement. This patient was seen most recently on 11/18/2013 for medications. Medications currently listed for the patient included OxyContin 30mg, Soma 350 mg, Cymbalta 30 mg, Lexapro 10 mg, docusate 250 mg, Lunesta 3 mg and Norco 10/325 mg. Physical examination of the patient noted that gait and station were normal, with the patient able to toe and heel stand as well as balance on either leg. Lumbar spine evaluation was noted to be unremarkable with active range of motion full in forward flexion and extension. However, extension was noted to be painful. Evaluation of motor strength revealed right leg muscle strength of 4/5 versus the left side at 5/5. Sensory was decreased in the right L5-S1 distribution. The notes indicated in the treatment plan that the patient received medication refills and was to continue to work full-time without restrictions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lunesta, 3 mg, for a 2 month supply:** 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)

**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, Insomnia Treatment

**Decision rationale:** The Physician Reviewer's decision rationale: The Official Disability Guidelines state that nonbenzodiazepine sedative-hypnotics are considered first-line medications for insomnia. This class of medications includes zolpidem (Ambien® and Ambien® CR), zaleplon (Sonata®), and eszopicolone (Lunesta®). Benzodiazepine-receptor agonists work by selectively binding to type-1 benzodiazepine receptors in the CNS. A review of systems indicates that the patient has a history of difficulty falling asleep. While the notes indicate that the patient has a prior history of difficulty falling asleep and maintaining sleep, there is no indication in the notes that the patient currently has insomnia complaints for which Lunesta may be used to address. Furthermore, there is no clear indication with the use of Lunesta that the patient has had any beneficial effect. The request for Lunesta, 3 mg, for a 2 month supply, is not medically necessary or appropriate.

**OxyContin, 30 mg, for a 2 month supply:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 92.

**Decision rationale:** The Physician Reviewer's decision rationale: According to the Chronic Pain Medical Treatment Guidelines, oxycodone controlled release (OxyContin®) is a controlled release formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. OxyContin tablets are NOT intended for use as an as needed analgesic. The Chronic Pain Medical Treatment Guidelines also states a recommendation for the 4 A's for ongoing monitoring. These four domains for monitoring have been summarized as the "4 A's" and include monitoring for 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. The Chronic Pain Medical Treatment Guidelines states that dosing of opioids is not recommended to exceed 120 mg oral morphine equivalents per day; and for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. The documentation submitted for review indicates that this patient is currently prescribed OxyContin Extended Release 30 mg tablets for use at 1 tablet 3 times per day as well as Norco 10/235 mg 1 tablet every 4 hours as needed. Based on the current recommendations of the guidelines, the patient's total morphine equivalent daily dose of 195 exceeds the recommendation of the guidelines for no more than 120 morphine equivalent dosage per day. Furthermore, there was a lack of documentation indicating that the patient has improvement in the ability to undertake activities of daily living with the use of OxyContin. The request for OxyContin, 30 mg, for a 2 month supply, is not medically necessary or appropriate.

**Norco, 10/325 mg, for a 2 month supply:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 92.

**Decision rationale:** The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines states that hydrocodone/acetaminophen is indicated for moderate to moderately severe pain. The Chronic Pain Medical Treatment Guidelines also states a recommendation for the 4 A's for ongoing monitoring. These four domains for monitoring have been summarized as the "4 A's" and include monitoring for 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. The Chronic Pain Medical Treatment Guidelines states that dosing of opioids is not recommended to exceed 120 mg oral morphine equivalents per day; and for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. The documentation submitted for review indicates that this patient is currently prescribed OxyContin Extended Release 30 mg tablets for use at 1 tablet 3 times per day as well as Norco 10/235 mg 1 tablet every 4 hours as needed. Based on the current recommendations of the guidelines, the patient's total morphine equivalent daily dose of 195 exceeds the recommendation of the guidelines for no more than 120 morphine equivalent dosage per day. Furthermore, there was a lack of documentation indicating that the patient has improvement in the ability to undertake activities of daily living with the use of Norco. The request for Norco, 10/325 mg, for a 2 month supply, is not medically necessary or appropriate.

**Docusate, 250 mg, for a 2 month supply:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids - Initiating Therapy Page(s): 77.

**Decision rationale:** The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines states the recommendation for prophylactic treatment of constipation at the initiation of opioid therapy. The documentation submitted for review indicates that the patient is currently being treated with opioid analgesics, and the guidelines recommend the initiation of prophylactic treatment of constipation with opioid therapy. The request for Docusate, 250 mg, for a 2 month supply, is medically necessary.

**Tizanidine, 4 mg, 20 count:** Upheld

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

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

**Decision rationale:** The Physician Reviewer's decision rationale: states that tizanidine is a centrally-acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain; with eight studies having demonstrated its efficacy for low back pain. One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome, and the authors recommended its use as a first line option to treat myofascial pain. Also, it may also provide benefit as an adjunct treatment for fibromyalgia. There was a lack of documentation submitted for review indicating that the patient currently has muscle spasms, for which tizanidine may be appropriate. The request for Tizanidine, 4 mg, 20 count, is not medically necessary or appropriate.