

<b>Case Number:</b>	CM13-0020910		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	05/13/2009
<b>Decision Date:</b>	04/10/2014	<b>UR Denial Date:</b>	08/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/06/2013

### 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 Physical Medicine & 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 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:

This is a patient with a date of injury of 5/13/09. A utilization review determination dated 8/15/13 recommends non-certification of Ambien, Soma, Nexium, Percocet, and Cymbalta. A 8/7/13 medical report identifies bilateral shoulder pain increased since last visit. Quality of sleep is noted to be poor. She states that medications are less effective. She is quite frustrated and would like to pursue surgery. On exam, there is limited neck ROM with tenderness. Shoulder ROM is limited with tenderness and positive orthopedic testing. There is 4/5 strength on left elbow flexors and extensors and bilateral shoulder flexors and abductors.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **AMBIEN/ZOLPIDEM TART ER 6.25 MG TABLETS QTY 30: 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 (ODG) Chronic Pain Chapter, Zolpidem (Ambien)<sup>1/2</sup>

**Decision rationale:** Regarding the request for Ambien, the Official Disability Guidelines (ODG) recommend short-term use (usually two to six weeks) for patients with insomnia. Within the

documentation available for review, there is no documentation of failure of non-pharmacologic treatment for insomnia, any significant improvement with the use of Ambien to date, and/or a clear rationale for the long-term use of the medication despite the recommendations of ODG against long-term use. In the absence of such documentation, the currently requested Ambien is not medically necessary.

**SOMA 350 MG TABLET TWICE A DAY:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** Regarding the request for Soma, the MTUS Chronic Pain Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Soma is not medically necessary.

**NEXIUM 40 MG CAPSULE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** Regarding the request for Nexium, the MTUS Chronic Pain Guidelines state that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Additionally, the ODG recommends Nexium for use as a 2nd line agent, after failure of omeprazole or lansoprazole. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. Furthermore, there is no indication that the patient has failed first-line agents prior to initiating treatment with Nexium. In light of the above issues, the currently requested Nexium is not medically necessary.

**PERCOCET 10-325 MG TABLET:** Upheld

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

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

**Decision rationale:** Regarding the request for Percocet, the MTUS Chronic Pain Guidelines state that, due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. In the absence of such documentation, the currently requested Percocet is not medically necessary.

**CYMBALTA 60MG DAILY QTY 30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

**Decision rationale:** Regarding the request for Cymbalta, the MTUS Chronic Pain Guidelines state that antidepressants are recommended as a 1st line option for neuropathic pain and as a possibility for non-neuropathic pain. Guidelines go on to recommend a trial of at least 4 weeks. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Within the documentation available for review, there is no identification that the Cymbalta provides any specific analgesic effect (in terms of reduced numeric rating scale or percent reduction in pain), or provides any objective functional improvement, reduction in opiate medication use, or improvement in psychological well-being. In light of the above issues, the currently requested Cymbalta is not medically necessary