

<b>Case Number:</b>	CM13-0041013		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	05/12/2007
<b>Decision Date:</b>	03/26/2014	<b>UR Denial Date:</b>	10/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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 & 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. 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 33-year-old female who reported an injury on 05/12/2007. The patient was treated conservatively with medications, physical therapy, activity modification, and psychological support. The patient ultimately underwent a spinal cord stimulator implantation. The patient's chronic pain continued to be managed with multiple medications. The patient was monitored for compliance with urine drug screens. The patient was evaluated on 07/02/2013, which documented that the patient had a straight leg raising test with radicular symptoms all the way down to her right foot. The patient's most recent clinical evaluation dated 09/05/2013 did not document any radicular findings. It was noted that the patient had undergone an MRI in 2011, and that the patient was being referred for surgical intervention for persistent radicular complaints despite conservative treatments. The patient's medications were listed as Prilosec, Gabapentin, Senna, MS Contin, Dilaudid, Zanaflex, Ambien, and Cymbalta. The patient's most recent pain level was documented as 7/10. The patient's diagnoses included multilevel degenerative disc disease and spondylosis with right lower extremity radicular pain, a history of GERD, long-acting and short-acting opioid therapy with adjuncts for her industrial injuries, and spasm sequelae. The patient's treatment plan was to include a referral for surgical intervention and continuation of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One lumbar MRI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The ACOEM Guidelines recommend an MRI when there is documentation of neurological deficits. The clinical documentation submitted for review does indicate that the patient has a positive right-sided straight leg raising test for radicular symptoms. However, Official Disability Guidelines do not recommend repeat imaging in the absence of significant progressive neurological deficits or a change in pathology. The clinical documentation submitted for review does indicate that the patient had an MRI in 2011. The clinical documentation submitted for review fails to provide evidence that the patient has progressive neurological deficit or any specific neurological deficits corresponding with nerve root impingement. Additionally, there is no documentation that the patient has had a significant change in pathology. As such, the requested 1 lumbar MRI is not medically necessary and appropriate.

**1 prescription Ambien 10mg #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, Pain (Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Insomnia Treatments

**Decision rationale:** The Official Disability Guidelines do not recommend the long-term use of this medication in the management of insomnia related to chronic pain. The clinical documentation submitted for review does indicate that the patient has been on this medication for an extended duration. Additionally, the clinical documentation fails to provide an adequate assessment of the patient's sleep hygiene to support pharmacological management of insomnia related to chronic pain. As such, the requested 1 prescription of Ambien 10 mg #30 is not medically necessary and appropriate.

**1 prescription Prozac 10mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines May 2009..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines section on Antidepressants.

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend the use of antidepressants in the management of a patient's chronic pain. However, the MTUS Chronic Pain Guidelines recommend that continued use be supported by documentation of functional benefit and symptom response. Although it is indicated that the patient had pain rated at a 7/10, the response

to medications is not documented. Additionally, there is no documentation of functional benefit related to prior use of this medication. Therefore, the continued use of Prozac would not be indicated. As such, the requested 1 prescription of Prozac 10 mg #30 is not medically necessary and appropriate.

**1 prescription Cymbalta 30mg #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): 60.

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend the use of antidepressants in the management of a patient's chronic pain. However, the California Medical Treatment Utilization Schedule recommends that continued use be supported by documentation of functional benefit and symptom response. Although it is indicated that the patient had pain rated at a 7/10, the response to medications is not documented. Additionally, there is no documentation of functional benefit related to prior use of this medication. Therefore, the continued use of Prozac would not be indicated. As such, the requested 1 prescription of Cymbalta 30 mg #30 is not medically necessary or appropriate.

**1 prescription Senna 8.6mg #180 with 3 refills: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation McKay SL, Fravel M, and Scanlon C. Management of constipation. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core; 2009 Oct. 5 p.

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

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend prophylactic treatment of constipation for patients initiated opioid therapy. However, the clinical documentation submitted for review does not provide a recent assessment of the patient's gastrointestinal system to support that the patient has continued side effects related to medication usage that require prophylactic management. As such, the requested 1 prescription of Senna 8.6 mg #180 with 3 refills is not medically necessary or appropriate.

**MS Contin 60mg #60: 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): 78.

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend the continued use of opioids in the management of chronic pain be supported by quantitative measurements of pain relief, documentation of functional benefit, an assessment of side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the patient is monitored for aberrant behavior with urine drug screens. However, the clinical documentation fails to provide any evidence of a quantitative assessment of pain relief regarding this medication to support the efficacy and continued use. Additionally, there is no documentation of functional benefit related to medication usage. As such, the requested MS Contin 60 mg #60 is not medically necessary and appropriate.

**1 prescription Dilaudid 4mg #180: 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): 78.

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend the continued use of opioids in the management of chronic pain be supported by quantitative measurements of pain relief, documentation of functional benefit, an assessment of side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the patient is monitored for aberrant behavior with urine drug screens. However, the clinical documentation fails to provide any evidence of a quantitative assessment of pain relief regarding this medication to support the efficacy and continued use. Additionally, there is no documentation of functional benefit related to medication usage. As such, the requested Dilaudid 4 mg #180 is not medically necessary and appropriate.

**1 prescription Zanaflex 4mg #120: Upheld**

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

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

**Decision rationale:** The MTUS Chronic Pain Guidelines do not recommend the extended use of muscle relaxers in the management of chronic pain. The clinical documentation submitted for review does indicate that the patient has been on this medication for an extended duration. The clinical documentation fails to provide extenuating circumstances that would support extending treatment beyond the MTUS Chronic Pain Guidelines' recommendation of 2 to 3 weeks of usage for this medication. Therefore, continued use would not be indicated. As such, the requested 1 prescription of Zanaflex 4 mg #120 is not medically necessary or appropriate.

**1 prescription Prilosec 20mg: Upheld**

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

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

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend the use of a gastrointestinal protectant for patients at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system to support that the patient is at risk for developing gastrointestinal related symptoms as a result of medication usage. Therefore, continued use of this medication would not be supported. As such, the requested 1 prescription for Prilosec 20 mg is not medically necessary and appropriate.

**1 prescription Gabapentin 600mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain and Antiepilepsy drugs Page(s): 16 and 60.

**Decision rationale:** The MTUS Chronic Pain Guidelines do not recommend the extended use of muscle relaxers in the management of chronic pain. The clinical documentation submitted for review does indicate that the patient has been on this medication for an extended duration. The clinical documentation fails to provide extenuating circumstances that would support extending treatment beyond the MTUS Chronic Pain Guidelines' recommendation of 2 to 3 weeks of usage for this medication. Therefore, continued use would not be indicated. As such, the requested 1 prescription of Zanaflex 4 mg #120 is not medically necessary or appropriate.