

<b>Case Number:</b>	CM13-0047389		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	07/28/2011
<b>Decision Date:</b>	04/25/2014	<b>UR Denial Date:</b>	09/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/01/2013

### 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 and Rehabilitation has a subspecialty in Sports Medicine and is licensed to practice in 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 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:

The patient is a 29-year-old female who reported an injury on 07/28/2011. The mechanism of injury was not provided in the medical records. The patient was diagnosed with degenerative lumbar/lumbosacral intervertebral disc lumbago thoracic or lumbosacral neuritis or radiculopathy, unspecified. The patient's symptoms include 10/10 pain without medications, unable to function, and 6/10 to 8/10 with medications. The patient was noted to be taking Amitriptyline/gabapentin for numbness and tingling, Norco for pain control, and Zanaflex for spasm control. The patient's lower extremity range of motion and strength was noted to be within functional limits and had decreased sensation to light touch. The patient was noted to have 30 degrees flexion and 0 extension of back. The patient had tenderness to palpation across her paraspinal muscles and spinous processes of the lumbar spine into myofascial tissue of left gluteal region.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **EVALUATION FOR A FUNCTIONAL RESTORATION PROGRAM: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 14-5, 51. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), PAIN CHAPTER

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
FUNCTIONAL RESTORATION PROGRAM Page(s): 30-32.

**Decision rationale:** The California MTUS Guidelines indicate that the criteria for entry into a functional restoration program includes an adequate and thorough evaluation that has been made including baseline functional testing so followup with the same test can note functional improvement, documentation of previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement, documentation of the patient's significant loss of the ability to function independently resulting from the chronic pain, documentation that the patient is not a candidate for surgery or other treatments would clearly be warranted, documentation of the patient having motivation to change and that they are willing to forego secondary gains including disability payments to affect this change, and negative predictors of success have been addressed. Additionally, the guidelines indicate the treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. As the Guidelines state, documentation of unsuccessful attempts of treating chronic pain would be needed, the documentation submitted for review indicated the patient's current medication has been helpful. The documentation also failed to indicate whether or not the patient is a candidate where surgery or other treatments would clearly be warranted and documentation of the patient's motivation to change, willingness to forego secondary gains including disability payments to affect this change. Therefore, the request is not supported. Given the above, the request for EVALUATION FOR A FUNCTIONAL RESTORATION PROGRAM is non-certified.

**OPANA ER 5 MG, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 82-8.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS  
Page(s): 78.

**Decision rationale:** According to the California MTUS Guidelines, the ongoing management of patients taking opioid medications should include detailed documentation of pain relief, functional status, and the 4 A's for ongoing monitoring which include analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The documentation submitted for review indicates the patient has a decrease in pain and an increase in function with the use of medications. However, the documentation failed to provide evidence of whether there had been reported adverse effects or aberrant drug taking behaviors. In the absence of detailed documentation, required by Guidelines for the ongoing use of opioid medications, the request for OPANA ER 5 MG, #60 is non-certified.

**NORCO 10/325, #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS  
Page(s): 78.

**Decision rationale:** According to the California MTUS Guidelines, the ongoing management of patients taking opioid medications should include detailed documentation of pain relief, functional status, and the 4 A's for ongoing monitoring which include analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The documentation submitted for review indicates the patient has a decrease in pain and an increase in function with the use of medications. However, the documentation failed to provide evidence of whether there had been reported adverse effects or aberrant drug taking behaviors. In the absence of detailed documentation, required by Guidelines for the ongoing use of opioid medications, the request for NORCO 10/325, #120 is non-certified.

**AMBIEN CR 12.5 MG, #30 WITH 3 REFILLS:** 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), PAIN CHAPTER

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), PAIN ZOLPIDEM

**Decision rationale:** According to the Official Disability Guidelines, Ambien is approved for the short-term (usually 2 to 6 weeks) treatment of insomnia. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long term. Ambien CR offers no significant clinical advantage over regular release zolpidem. Due to adverse effects, FDA now requires lower doses for zolpidem. The dose of zolpidem for women should be lowered from 12.5 mg to 6.25 mg for ER products. As the requested medication would be supported for short-term use, the requested dosage 12.5 mg exceeds the FDA Guidelines due to adverse effects. Therefore, the request is not supported. Given the above, the request for AMBIEN CR 12.5 MG, #30 WITH 3 REFILLS is non-certified.

**AMITRIPTYLINE 25 MG, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 14-15.

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

**Decision rationale:** According to the Official Disability Guidelines, antidepressants for chronic pain are recommended as a first line option for neuropathic pain, and as a possibility for non-

neuropathic pain. Tricyclics are generally considered a first line agent unless they are ineffective, poorly tolerated, or contraindicated. 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. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. The documentation submitted for review indicates the patient is taking gabapentin for neuropathic pain. The documentation failed to indicate the need for an additional medication for neuropathic pain. Therefore, the request is not supported. Given the above, the request for AMITRIPTYLINE 25 MG, #60 is non-certified.