

<b>Case Number:</b>	CM13-0064586		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	10/11/2003
<b>Decision Date:</b>	05/16/2014	<b>UR Denial Date:</b>	12/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2013

### 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 Anesthesiology, and is licensed to practice in Florida. 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 injured worker is a 43-year-old female who reported an injury on 10/11/2003. The mechanism of injury was not provided within the medical records. The injured worker's course of treatment to date includes multiple imaging and diagnostic studies, all of which have produced normal findings. Due to the extent of the injured worker's subjective complaints in comparison to her diagnostic findings, the injured worker was referred for psychiatric care. The psychologic evaluation initially diagnosed the injured worker with somatoform disorder and major depression. She was later diagnosed with chronic dysthymia. MRI of the brain in 10/2010 indicated that she possibly had a demyelinating disease, such as multiple sclerosis; however, this diagnosis is not found anywhere in the medical records. It was evidenced throughout the medical history that the injured worker was not forthcoming in disclosing her entire clinical picture and previous medical treatment, to the multiple doctors from whom she seeks treatment. Additionally, the injured worker has had imaging with sub rosa films, and findings were in stark contrast to the injured worker's subjective complaints. The injured worker has been maintained on numerous medications, with subsequent increases despite no progression of symptoms or evidence of specific pathophysiology. The injured worker's current medications include Atarax 25 mg, Percocet 10/325 mg, Lyrica 150 mg, Elavil 50 mg, Ambien CR 12.5 mg, and Zanaflex 2 mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**120 PERCOCET 10/325MG:** 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): 74-95.

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend opioids to treat moderate to severe chronic pain. For ongoing management of opioid therapy, Guidelines recommend that an assessment of functional ability be obtained at 6-month intervals, using a numerical scale or validated instrument; a thorough pain assessment be performed at each clinical visit; and frequent random urine drug screens be performed to monitor compliance. The clinical information submitted for review provided evidence that the injured worker has been utilizing Percocet for over a year, with no pain levels being obtained from 01/2013 to the present. It was noted throughout the last year of clinical notes, the injured worker's pain remained unchanged, and that in the last 2 most recent notes submitted for review dated 08/27/2013 and 09/24/2013, the injured worker's pain symptoms have increased. Furthermore, there was no inclusion or documentation noting a recent urine drug screen; the last noted results in 02/2012 were consistent. The most recent lumbar range of motion values were obtained on 09/24/2013 and included flexion of 35 degrees and extension of 7 degrees. As the clinical information submitted for review did not provide evidence of increased function or decreased pain with use of the pain medications, or a thorough pain assessment as a direct result of the pain medication use, medical necessity and medication efficacy cannot be determined. The request for 120 Percocet 10/325 mg is not medically necessary and appropriate.

**60 ZANAFLEX 2MG:** 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): 63-66.

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend non-sedating muscle relaxants as a second-line treatment for acute exacerbations of chronic low back pain. Zanaflex in particular is an antispasmodic that has demonstrated efficacy for low back pain. The clinical information submitted for review provided evidence that the injured worker has been utilizing this medication for over a year, with no resolution of her back spasms. Additionally, there is no discussion regarding the effect the medication has on the injured worker's overall function and pain levels; however, the injured worker has reported no change in pain levels and an actual increase in levels, in the recent months. As this medication has failed to resolve spastic symptoms, and there is no evidence that it has affected her overall pain or functional levels, continued use is not indicated at this time. As such, the request is not medically necessary and appropriate.

**2 AMBIEN CR 12.5MG:** 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), Pain, Insomnia Treatment

**Decision rationale:** The ODG recommends Ambien CR to treat insomnia, for a duration of less than 35 days. Additionally, new FDA Guidelines recommend decreasing Ambien CR products from 12.5 mg to 6.25 mg in women, due to their adverse side effect profile. Furthermore, guidelines recommend that specific sleep components should be addressed in determining efficacy of a medication. These components include sleep onset, sleep maintenance, sleep quality, and next-day functioning. The clinical information submitted for review had a simple statement that the injured worker's "quality of sleep was fair", and noted that she has been utilizing Ambien for at least 2 months. There was no discussion regarding the injured worker's next-day functioning, rapidity of sleep onset, or sleep maintenance. Additionally, the length of use of 2 months, and dose of 12.5 mg, exceed ODG recommendations of treatment for less than 35 days with a decrease of dosing to 6.5 mg in female injured workers. However, this medication is not recommended for abrupt discontinuation, and it is expected that the physician will allow for safe weaning. As such, the request for 2 Ambien CR 12.5 mg is not medically necessary and appropriate.