

<b>Case Number:</b>	CM14-0101167		
<b>Date Assigned:</b>	09/24/2014	<b>Date of Injury:</b>	07/30/2011
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/01/2014

### 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 Occupational Medicine 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:

The injured worker is a 53 year-old male who sustained an injury on 9/19/93. As per the 8/27/14 report he continued to complain of thoracic back pain with radiation to the right flank. Pain level was 6-8/10. An exam indicated decreased range of motion (ROM) of torso, thoracic spine tenderness, right greater than left and sensory deficits in T4-7 dermatomes on the right side. Thoracic magnetic resonance imaging (MRI) from 8/10/11 revealed degenerative disc disease (DDD), disc bulge, disc space narrowing with thecal sac deformity and lumbar magnetic resonance imaging (MRI) revealed T12-L2 disc space narrowing, L2-5 facet hypertrophy, L3-4 disc bulge with annular degeneration deforming thecal sac, and stenosis, L4-5 degenerative disc disease (DDD), disc herniation with annular tear, stenosis and foraminal encroachment, L5-S1 degenerative disc disease (DDD) with annular tear with compression of exiting left (LT) L5 nerve root. He underwent a laminectomy at L4-5 in 1996 and recent requests for lumbar surgery and intrathecal pump were denied. He is currently on OxyContin, zolpidem tartrate (Ambien), Prozac, carisoprodol (Soma), and Percocet. Previous treatments included medications, epidural steroid injections (ESIs), facet blocks, and physical therapy. He has been on long-term use of Ambien and Soma and reported continued ability to fall asleep, stay asleep, and awaken well rested with the use of Ambien for his chronic insomnia due to industrial injury and continued benefit with use of Soma for his muscle spasms. He reported no significant benefit with thoracic epidural steroid injection (TESI) performed on 8/15/14. On 7/30/14 he reported continued 30-40% relief with the use of his Percocet max 8/day which allowed him to remain functional and active, but on 8/27/14 visit he reported decreased efficacy of Percocet for his chronic pain. Diagnoses include lumbago, lumbar degenerative disc disease (DDD), post-laminectomy syndrome, sciatica, and thoracic pain. The request for Ambien 10mg #30 was modified to

Ambien 10mg #20, Soma 350mg #90 was modified to Soma 350mg #20, and Percocet 10-325mg #240 was modified to Percocet 10-325mg #60 on 06/24/14.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**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 disabilities 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, Ambien® (zolpidem tartrate)

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) guidelines do not address the issue in dispute and hence the Official Disability Guidelines (ODG) have been consulted. As per the Official Disability Guidelines (ODG), Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain, which has not been addressed in this case. Additionally, it is unclear from the records for how long he has been prescribed this medication since guidelines only recommend short-term use for 2-6 weeks. Thus, the request for Ambien 10mg #30 is not medically necessary and appropriate.

**Soma 350mg #90:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disabilities guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma), Page(s): 29.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) guidelines, states that this medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Abuse has been noted for sedative and relaxant effects. In regular abusers the main concern is the accumulation of meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. This includes the following: (1) increasing sedation of benzodiazepines or alcohol; (2) use to prevent side effects of cocaine; (3) use with tramadol to produce relaxation and euphoria; (4) as a combination with hydrocodone, an effect that some abusers claim is similar to heroin; & (5) as a combination with codeine. In this case, there is no evidence of substantial spasm, refractory to first line therapy. There is no documentation of any significant improvement with continuous use. Long term use of antispasmodics is not recommended. Therefore, the request for Soma 350 mg #90 is not medically necessary and appropriate.

**Percocet 10-325mg #240:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, Page(s): 91.

**Decision rationale:** According to the California Medical Treatment Utilization Schedule (MTUS) guidelines, Percocet (Oxycodone & Acetaminophen) as a short acting opioid is recommended for chronic pain management under certain criteria. As per California Medical Treatment Utilization Schedule guidelines, "four domains have been proposed as most relevant for ongoing monitoring of chronic pain injured workers on opioids; pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors)." Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the Opioid; how long it takes for pain relief; and how long pain relief lasts. In this case, there is little to no documentation of any significant improvement in pain level (i.e. visual analog scale [VAS]) with use of this medication. There is no evidence of urine drug test in order to monitor compliance. Furthermore, conversion to long-acting opioids should be considered when frequent dosing of short-acting opioid for continuous around the clock pain relief is desired. The medical documents do not support continuation of Percocet with current dosing. Therefore, the request for Percocet 10/325mg # 240 is not medically necessary and appropriate.