

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0117171 | | |
| Date Assigned: | 08/06/2014 | Date of Injury: | 01/21/2005 |
| Decision Date: | 09/10/2014 | UR Denial Date: | 07/17/2014 |
| Priority: | Standard | Application Received: | 07/25/2014 |

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 patient is a 53-year-old male who has submitted a claim for cervicalgia, cervical disc displacement, and acquired spondylolisthesis associated with an industrial injury date of January 21, 2005. Medical records from 2012-2014 were reviewed and showed that patient complained of ongoing neck pain, rated 5/10 in severity. The pain radiates to the back of the right arm and right scapula. There was also low back pain rated 4-6/10 in severity. Physical examination showed pain on extension of the cervical spine. Motor strength was 4/5 on the left biceps and triceps. There was decreased sensation on the left lateral forearm and lateral arm. Left triceps reflex was 1+. Spurling's test was positive. Examination of the lumbar spine showed spasms next to the spinous processes with the patient relaxed lying prone. Lumbar range of motion was limited due to pain. Motor strength was 4/5 on the left extensor hallucis longus and there was diminished sensation over the dorsum of the foot. Straight leg raise test was positive bilaterally. MRI of the lumbar spine, dated February 11, 2014, revealed bilateral laminectomy defects at L3-L4 through L5-S1 and a discectomy with interbody fusion and posterolateral fixation with pedicle screws at L5 and S1, L2-L3 broad-based disc protrusion and facet hypertrophy producing bilateral neuroforaminal narrowing, L3-L4 left paracentral disc protrusion that impinges the left L3 exiting nerve root with facet hypertrophy producing left greater than right neuroforaminal narrowing, L4-L5 broad-based disc protrusion and facet hypertrophy producing bilateral neuroforaminal narrowing with left greater than right impingement on the L4 exiting nerve roots and posterior annular tear fissure, and L5-S1 grade 2 spondylolisthesis of L5 with disc protrusion, facet hypertrophy and right neuroforaminal narrowing. Treatment to date has included medications, physical therapy, home exercise program, activity modification, lumbar epidural steroid injections, and lumbar spine fusion surgery. Utilization review, dated July 18, 2014, denied the request for Duragesic patch 50mcg #10 because there was no documentation that

requires continuous, around-the-clock opioid administration for an extended period of time, and cannot be managed by other means; denied the request for Soma 350mg #120 because there was no documentation of acute muscle spasms and the intention to treat over a short course; denied the request for Ambien 10mg #30 because there was no documentation of an intention to treat over a short course; and denied the request for Lidoderm 5% patches #60 because there was no documentation of evidence of trial of first-line therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duragesic patch 50 mcg. # 10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s) : 44. Decision based on Non-MTUS Citation www.drugs.com/pro/duragesic.html.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (Fentanyl Transdermal System) Page(s): 44.

Decision rationale: According to page 44 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Duragesic is not recommended as a first-line therapy. The FDA-approved product labeling states that Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. In this case, Duragesic patches were being prescribed since at least January 2014. Patient uses this medication for the relief of severe chronic pain. However, there was no documentation of functional improvement with this medication. Furthermore, there was no discussion regarding failure of other forms of treatment nor was there a discussion regarding the need for continuous opioid analgesia. Therefore, the request for Duragesic patch 50 mcg. # 10 is not medically necessary.

Soma 350 mg. # 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s) : 63. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain Chapter: Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29, 65.

Decision rationale: As stated on pages 29 and 65 of CA MTUS Chronic Pain Medical Treatment Guidelines, Carisoprodol (Soma) is a centrally acting skeletal muscle relaxant. It is not recommended and is not indicated for long-term use. Guidelines state that its use is not recommended for longer than a 2 to 3 week period. Carisoprodol is metabolized to meprobamate, an anxiolytic that is a schedule IV controlled substance. In addition, abuse has been noted for sedative and relaxant effects. Carisoprodol abuse has been noted in order to augment or alter effects of other drugs such as hydrocodone, tramadol, benzodiazepine and codeine. In this case, patient has been prescribed Soma since at least January 2014. Patient uses this medication for the relief of spasms. Although muscle spasm on the lumbar area was evident in the recent progress

report dated May 21, 2014, there was no documentation of functional improvement with this medication. Furthermore, long-term use of this medication is not recommended. Therefore, the request for Soma 350 mg. # 120 is not medically necessary.

Ambien 10 mg. # 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 (ODG): Pain Chapter : AmbienPhysicians Desk Reference (PDR).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Zolpidem.

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), was used instead. ODG states Ambien (zolpidem) is a prescription short acting nonbenzodiazepine 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 and often is hard to obtain. In this case, the patient was prescribed Ambien since at least January 2014. However, there was no documentation of functional improvement with this medication. There was also no documentation of continued functional improvement and alleviation of sleep problems despite chronic use of this medication. There is no clear indication for continued use of Ambien. Therefore, the request for prescription of Ambien 10mg #30 is not medically necessary.

Lidoderm 5% patches # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): : 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56-57.

Decision rationale: As stated on page 56-57 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Lidoderm is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or and AED such as gabapentin or Lyrica). In this case, the patient has been using Lidoderm patches since at least January 2014. However, there was no documentation of the objective and functional benefits derived from use of Lidoderm patches. Furthermore, medical records submitted for review show no evidence of previous trials with first-line anti-depressants or anti-epileptics drugs. Therefore, the request for Lidoderm 5% patches # 60 is not medically necessary.