

<b>Case Number:</b>	CM14-0171519		
<b>Date Assigned:</b>	10/23/2014	<b>Date of Injury:</b>	11/12/2002
<b>Decision Date:</b>	11/25/2014	<b>UR Denial Date:</b>	09/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2014

### 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 Family Medicine and is licensed to practice in Arizona. 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:

Patient is a 45 year old female with a date of injury on 11/12/2002. Subjective complaints are of left lumbar and left patella pain radiating to the foot. There are also complaints of chronic sleep disturbances, and neck pain. Physical exam shows lumbar tenderness, and limited range of motion. Prior treatments include medications, activity restriction, rest, neurostimulator, TENS, physical therapy, psychotherapy, and spinal cord stimulator. Medications include Ambien, Soma, oxycodone, and Percocet. Submitted documentation indicates the patient is stable on the current regimen, and medications improve activities of daily living, and provides pain relief.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325mg #90:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** The patient in question has been on chronic opioid therapy. CA Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily

living, adverse side effects, or aberrant drug taking behavior. For this patient, documentation shows stability on medication, increased functional ability, and no adverse side effects. Furthermore, documentation is present of MTUS opioid compliance guidelines including urine drug screens, risk assessment, and ongoing efficacy of medication. The use of this medication is consistent with guidelines and is indicated for this patient. Therefore, Percocet 10/325mg #90 is medically necessary and appropriate.

**Soma 350mg #60:** Upheld

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

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

**Decision rationale:** CA MTUS does not recommend Carisoprodol. This medication is not indicated for long-term use. This medication is only recommended for a 2-3 week period. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. This patient has used Carisoprodol chronically, which is not consistent with current guidelines. Therefore, Soma 350mg #60 is not medically necessary and appropriate.

**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 (ODG), Chapter Pain, Zolpidem (Ambien)

**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:** ODG suggests that Zolpidem is only approved for the short-term treatment of insomnia. The recommended time-frame of usage is usually 2 to 6 weeks and long-term use is rarely recommended. Sleeping pills can be habit-forming, impair function and memory, and increase pain and depression over long-term use. Submitted documentation indicates the patient has been using this medication chronically. Continuation of this medication exceeds recommended usage per guidelines, and is not indicated. Therefore, the request for Ambien 10mg #30 is not medically necessary and appropriate.

**Oxycodone 30mg #90:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Specific Drug List.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids  
Page(s): 74-96.

**Decision rationale:** The patient in question has been on chronic opioid therapy. CA Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. For this patient, documentation shows stability on medication, increased functional ability, and no adverse side effects. Furthermore, documentation is present of MTUS opioid compliance guidelines including urine drug screens, risk assessment, and ongoing efficacy of medication. The use of this medication is consistent with guidelines and is indicated for this patient. Therefore, Oxycodone 30mg #90 is medically necessary and appropriate.