

<b>Case Number:</b>	CM14-0023817		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	06/08/2010
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	02/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2014

### 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 Physical Medicine and Rehabilitation 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 51-year-old female with a reported injury date on 06/08/2010. The mechanism of injury was not provided. Her diagnoses include degenerative cervical spondylosis, myofascial pain syndrome, pain disorder with psychological/general medical condition, and insomnia that is persistent due to chronic pain. A clinical note dated 02/04/2014 noted that the injured worker had complaints of chronic neck pain due to degenerative spondylosis of the cervical spine that radiates into the bilateral upper extremities, left greater than right. It was noted that the pain appeared to be in the C5-6 dermatomal distribution. It was noted that the injured worker wanted to use as little amount of pain medications as possible. On physical examination of the cervical spine, it was noted there was sensory loss/alteration in the C6 dermatome distribution in the left hand. In addition, it was noted that the injured worker had difficulty lifting and holding up her arms. There were positive spasms in both arms, right greater than left, and deep tendon reflexes were measured at 3+ at the biceps bilaterally. The injured worker's current medication regimen included methadone 10 mg, Percocet 10/325 mg, Flexeril 10 mg, and Lunesta 3 mg; this current regimen has been prescribed since at least 12/27/2013. The treatment plan noted that the physician wanted to continue the current analgesic medication plan to control pain. A Request for Authorization for methadone 10 mg #100, Percocet 10/325 mg #120, Flexeril 10 mg # 120, and Lunesta 3 mg #160 was submitted on 02/24/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**100 tablets of Methadone 10mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Methadone Page(s): 41-42, 61-62.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Methadone, Opioids, criteria for use Page(s): 61, 78.

**Decision rationale:** The California MTUS Guidelines state that methadone may be recommended as a second-line drug for moderate to severe pain if the potential benefit outweighs the risks. In addition, the guidelines state that injured workers who are prescribed opioid medications require ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Furthermore, the guidelines state that pain assessments should also be documented to include current pain, least reported pain over the period since last examination, average pain, intensity of pain after taking the opioid, how long it takes for pain relief to occur, and how long the pain relief lasts. This request remains unclear, as there is a lack of documentation of an adequate pain assessment as well as lack of documentation of screening for appropriate medication use and/or side effects. Additionally, it remains unclear whether this requested medication has provided a therapeutic effect. As such, this request is not medically necessary and appropriate.

**120 tablets of flexeril 10mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64.

**Decision rationale:** The California MTUS Guidelines state that cyclobenzaprine may be recommended for a short course of therapy as it is not recommended to be used for longer than 2 to 3 weeks. It was documented that the patient had been prescribed this medication for longer than 3 weeks. Additionally, there is a lack of evidence that this requested medication has provided a therapeutic effect, as there is a lack of documentation of adequate pain assessment. As such, this requested medication is not medically necessary and appropriate.

**120 tablets of 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): 75, 78.

**Decision rationale:** The California MTUS Guidelines state that short-acting opioids may be recommended for controlling chronic pain and are often used for intermittent or breakthrough pain. In addition, the guidelines also state that patients who are prescribed opioid medications

require ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, the guidelines state that there should be documentation of adequate pain assessment, to include current pain, least reported pain over the period since last examination, average pain, intensity of pain after taking the opioid, how long it takes for pain relief to occur, and how long the pain relief lasts. This request remains unclear as there is a lack of documentation showing that the patient has been screened for appropriate medication use and/or side effects. Additionally, there is a lack of adequate pain assessment provided within the documentation for review showing that this medication has provided a therapeutic effect. As such, this requested medication is not medically necessary and appropriate.

**60 tablets of lunesta 3mg: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Treatment Index, 11th Edition (web), 2013, Pain Chapter, Insomnia Treatment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Insomnia treatment.

**Decision rationale:** The Official Disability Guidelines state that Lunesta may be recommended for the treatment of insomnia. In addition, the guidelines state that the specific component of the injured workers insomnia should be addressed to include sleep onset, sleep maintenance, sleep quality, and/or next day functioning. Although there is a diagnosis of insomnia that is persistent due to chronic pain, there is a lack of symptomatology showing that the patient suffers from insomnia that would benefit from the use of this medication. Additionally, there is a lack of documentation showing that this medication has provided a therapeutic effect. Furthermore, there is a lack of documentation of a specific component of insomnia that is being treated. As such, this requested medication is non-medically necessary and appropriate.