

<b>Case Number:</b>	CM14-0049525		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	02/01/2004
<b>Decision Date:</b>	08/19/2014	<b>UR Denial Date:</b>	04/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2014

### 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 & Rehabilitation and is licensed to practice in Texas and Ohio. 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 50-year-old female who reported an injury on 02/01/2004. The injured worker's medication history included Neurontin 800 mg tablets 1 three times a day, Soma 350 mg tablets 1 daily, Ambien 10 mg tablets at bedtime as needed and Percocet 10/325 mg 1 daily as needed as of 11/2013. The documentation of 03/28/2014 revealed that the injured worker's pain with medications was a 4/10; and without medication, it was a 9/10. The injured worker noted no new problems or side effects. The quality of sleep was noted to be good. The injured worker denied side effects. Prior treatments included epidural steroid injections. The treatment plan included that physical therapy was on hold due to asthma. In addition, the injured worker was utilizing Flexeril for severe spasms when Soma did not adequately decrease severe acute spasms. The documentation indicated that the Soma was for moderate spasms, and the injured worker reported daily active acute muscle spasms, starting in the low back and radiating into the upper back. The injured worker noted that she was able to control spasms with Soma and Flexeril. The injured worker indicated that with the Ambien, the injured worker would take the medication if she was unable to sleep at 10 o'clock at night. With the use of Ambien, the injured worker would sleep through the entire night, getting approximately 8 hours of sleep. The injured worker was to continue with Percocet for moderate to severe pain and to continue Neurontin to address radicular pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Soma 350mg #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** The California MTUS Guidelines recommend muscle relaxants as a second-line option for the short-term treatment of acute low back pain. Their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated that the injured worker had been utilizing the medication since at least 11/2013. There was a lack of documentation of objective functional improvement with the medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Soma 350 mg #30 is not medically necessary.

**Percocet 10/325 mg #90:** 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 (Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain (Ongoing Management and Opioid Dosing) Page(s): 60, 78, 86.

**Decision rationale:** The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement and an objective decrease in pain. There should be documentation that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated that the injured worker had utilized the medication since at least 11/2013. The injured worker had an objective decrease in pain. There was a lack of documentation of objective functional improvement and that the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Percocet 10/325 mg #90 is not medically necessary.

**Ambien CR 12.5mg #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 (Chronic).

**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 Official Disability Guidelines indicate that Ambien is recommended for the short-term treatment of insomnia. The short-term treatment is for 2 to 6 weeks. Additionally, Ambien CR offers no significant clinical advantage over the regular release zolpidem. The clinical documentation submitted for review indicated that the injured worker had been utilizing the medication for greater than 6 weeks. There was documentation that the injured worker could sleep better with the medication, for up to 8 hours. However, the request as submitted failed to provide the requested frequency. Additionally, there was a lack of documentation to warrant nonadherence to the guideline recommendations for usage. Given the above, the request for Ambien CR 12.5 mg #30 is not medically necessary.

**Neurontin 800mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epileptic Drugs Page(s): 16.

**Decision rationale:** The California MTUS Guidelines recommend antiepilepsy medications as a first-line medication for the treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30% to 50% and objective functional improvement. The clinical documentation submitted for review indicated that the injured worker had a decrease of pain with medications. However, there was a lack of documentation indicating objective functional benefit. The request as submitted failed to indicate the frequency for the requested medication. The duration of use was at least 3 months. Given the above, the request for Neurontin 800 mg #120 is not medically necessary.