

<b>Case Number:</b>	CM14-0087863		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	09/12/2001
<b>Decision Date:</b>	10/06/2014	<b>UR Denial Date:</b>	05/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2014

### 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, has a subspecialty in Interventional Spine 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 65 year old with an injury date on 9/12/01. Patient complains of continued cervical pain that radiates into her left shoulder, with pain rated 9/10 with medications per 4/2/14 report. Patient also has lower back pain and bilateral lower extremity pain, along with numbness on bilateral hands due to carpal tunnel syndrome per 4/2/14 report. Patient states she also has headaches, dizziness, and loss of memory due to cervical pain per 4/2/14 report. Based on the 4/2/14 progress report the current diagnosis are cervical degenerative disc disease, multiple disc herniation/bulges, cervical spine, cervical radiculopathy left C2-3, C3-4, C4-5, C5-6 and C6-7, cervical spine s/s syndrome and depression and anxiety. Exam on 4/2/14 showed "restricted range of motion of C-spine. There was a positive compression test of C-spine. Straight leg raise test is positive bilaterally." The treating doctor is requesting Percocet 10/325mg #150, Ambien CR 6.5 #30, Soma 350 #60, B-12 injection #10 ml 1cc 1M (intramuscular) weekly, and Gabapentin/Cyclobenzaprine 10%/10% 30gm cream #1 DOS 3/5/14. The utilization review determination being challenged is dated 5/17/14. [REDACTED] is the requesting provider, and he provided treatment reports from 10/5/13 to 4/15/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 10/325 mg # 150:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78.

**Decision rationale:** This patient presents with neck pain radiating into left shoulder. The treater has asked for Percocet 10/325mg #150 on 4/2/14. Patient has been taking Percocet since 3/5/14. The patient has not returned to work as of 4/2/14 report. For chronic opioids use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, the treater indicates a decrease in pain with current medications which include Percocet, but there is no discussion of this medication's efficacy in terms of functional improvement, quality of life change, or increase in activities of daily living. Given the lack of sufficient documentation regarding chronic opiates management as required by MTUS, this request is not medically necessary.

**Ambien CR 6.5 # 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 Integrated Treatment/Disability Duration Guidelines - Stress and Mental Illness Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC guidelines, Chronic Pain Chapter, Insomnia Treatment, for Ambien states: 2) Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists): First-line medications for insomnia. This class of medications includes zolpidem (Ambien® and Ambien® CR), zaleplon (Sonata®), and eszopiclone (Lunesta®). Benzodiazepine-receptor agonists work by selectively binding to type-1 benzodiazepine receptors in the CNS.

**Decision rationale:** This patient presents with neck pain radiating into left shoulder. The treater has asked for Ambien CR 6.5 #30 on 4/2/14. Patient has been taking Ambien since 10/8/13, and is still taking it as of 4/15/14 report. Ambien CR is indicated by Official Disability Guidelines (ODG) for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien CR to be effective for up to 24 weeks in adults. Not recommended for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. In this case, the patient has been taking Ambien for at least 5 months, and the treater does not explain the necessity of taking ambient CR along with regular Ambien. Neither medication is indicated for very long-term use. Therefore, the request for Ambien CR 6.5 #30 is not medically necessary.

**Soma 350 # 60 mg: Upheld**

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

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

**Decision rationale:** This patient presents with neck pain radiating into left shoulder. The treater has asked for soma 350 #60 on 4/2/14. Patient has been taking Soma since 10/8/13. Regarding Soma, MTUS does not recommend for longer than a 2 to 3 week period. Abuse has been noted for sedative and relaxant effects. In this case, the patient has been taking Soma for more than 5 months, but MTUS states that it is only indicated for short-term use only (2-3 weeks). Therefore, the request for Soma 350 #60 is not medically necessary.

**B-12 injection # 10 ml 1cc IM (intramuscular) weekly: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Vitamin B 12

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation AETNA Clinical Policy Bulletin: Vitamin B-12 Therapy Number: 0536 Policy I. Aetna considers vitamin B-12 injections medically necessary only for members with current or previously documented B-12 deficiency and any of the following diagnoses and conditions: A. Anemia - Fish tapeworm anemia; or - Macrocytic anemia; or - Megaloblastic anemia; or - Pernicious anemia (Addisonian anemia, Biermer's anemia). B. Gastrointestinal disorders

**Decision rationale:** This patient presents with neck pain radiating into left shoulder The treater has asked for B-12 injection #10 ml 1cc 1M (intramuscular) weekly on 4/2/14. Regarding Vitamin B-12 Therapy, Aetna considers the injections medically necessary only for members with current or previously documented B-12 deficiency and any of the following diagnoses and conditions: Anemia, gastrointestinal disorders, neuropathy, dementia secondary to vitamin B-12 deficiency, Homocystinuria, members receiving methotrexate or pralatrexate, members receiving pemetrexed, members with vitamin B-12 deficiency due to use of metformin that is not corrected by oral vitamin B-12, methylmalonic aciduria, or retrobulbar neuritis associated with heavy smoking, also known as tobacco amblyopia. In this case, the patient does not present with any of the diagnoses indicated for B-12 injections per Aetna policy bulletin. Therefore, this request is not medically necessary.

**Compound: Gabapentin/Cyclobenzaprine 10% 10% 30 gm cream # 1 (DOS:3/5/14): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medicine, Salicylate topicals Page(s): 111-113, 105.

**Decision rationale:** This patient presents with neck pain radiating into left shoulder. The treater has asked for gabapentin/cyclobenzaprine 10%/10% 30gm cream #1 DOS 3/5/14 on 4/2/14. Regarding topical analgesics, MTUS state they are largely experimental in use with few randomized controlled trials to determine efficacy or safety, and recommends for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS states "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS does not recommend Gabapentin for topical use. As such, this request is not medically necessary.