

<b>Case Number:</b>	CM15-0000435		
<b>Date Assigned:</b>	01/12/2015	<b>Date of Injury:</b>	08/24/2004
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	12/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/02/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 48 year old female who sustained an industrial injury on 08/24/2014. She had reported an injury to her right shoulder. The diagnoses are chronic regional pain syndrome to the right upper extremity, right shoulder, neck and upper extremities pain. Treatments to date have included medications. Currently, the IW complains of severe pain in the right upper extremity which is exacerbated with any use of the arm and temperature changes. The physician stated the injured worker remains quite symptomatic at this time and has difficulty sleeping at night secondary to the pain. There were objective findings of hypersensitivity and allodynia of the right upper extremity hand and fingers. On 12/10/2014, the injured worker submitted an application for IMR for review of 60 Tablets of Norco 7.5/325mg with 2 Refills, 60 Tablets of Lyrica 75mg with 2 Refills, and 30 Tablets of Ambien 10mg with 2 Refills. On 12/17/2014, Utilization Review non-certified the Ambien and modified the Norco and Lyrica request to 30 tablets with no refills. Utilization Review stated that objective evidence of clinical and functional improvements were not noted in the records regarding the Lyrica and Norco. With regards to the Ambien, Guidelines state that it is a short-acting nonbenzodiazepine hypnotic, which is approved for short-term (usually two to six weeks) treatment of insomnia. The MTUS, ACOEM Guidelines, (or ODG) was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**60 Tablets of Norco 7.5 MG/325 MG with 2 Refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 74-96. Decision based on Non-MTUS Citation Pain Chapter Opioids

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that opioids can be utilized for short term treatments of exacerbation of musculoskeletal pain that did not respond to standard treatment with NSAIDs and PT. The chronic use of opioids can be associated with the development of tolerance, dependency, sedation, addiction and adverse interaction with other sedatives. The records indicate that the patient had utilized opioids for many months. There is no documentation of the guidelines required compliance monitoring including UDS, absence of aberrant drug behavior and functional restoration. The patient did not report significant pain relief with utilization of the medications. The criteria for Norco 7.5/325mg #60 2 refills was not met.

**60 Tablets of Lyrica 75 MG with 2 Refills: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 16-22. Decision based on Non-MTUS Citation Pain Chapter Anticonvulsants

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that anticonvulsants can be utilized as first line medications for the treatment of neuropathic pain syndrome. The records indicate that the patient had subjective and objective findings consistent with a diagnosis of neuropathic pain. There was significant objective findings of allodynia and hypersensitivity of the upper extremity. There is no documentation of adverse medication effect with utilization of Lyrica. The criteria for the use of Lyrica 75mg #60 with 2 refills was met.

**30 Tablets of Ambien 10 MG with 2 Refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 24. Decision based on Non-MTUS Citation Pain Chapter Sedatives and Hypnotics

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that sedatives/hypnotics can be utilized for short time periods for the treatment of insomnia associated with chronic pain syndrome. The chronic use of sleep medications can be associated with the development of tolerance, dependency, addiction, daytime somnolence and adverse

interaction with other sedatives. The records indicate that the patient had utilized Ambien longer than the guidelines recommended duration of 6 weeks. The patient is also utilizing opioids and other medications with sedative effects. There is no documentation that the insomnia was fully investigated or that the patient failed non medication treatments. The criteria for the use of Ambien 10mg #30 2 refills was not met.