

<b>Case Number:</b>	CM15-0005737		
<b>Date Assigned:</b>	01/20/2015	<b>Date of Injury:</b>	01/28/2004
<b>Decision Date:</b>	04/10/2015	<b>UR Denial Date:</b>	12/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/12/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

### 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 55 year old female, who sustained an industrial injury on January 28, 2004. The diagnoses have included left lumbar radiculopathy exacerbation with chronic lumbar strain, cervical strain, right great than left, with right cervical radiculopathy, bilateral wrist and hand pain/paresthesia with clinical and electrodiagnostic bilateral carpal tunnel syndrome, bilateral shoulder strain with impingement, status post right shoulder surgery April 22, 2009, thoracic outlet syndrome, bilateral ankle feet/strain, right greater than left, secondary depression due to significant pain, gastric reflux, Xerostomia causing various dental difficulties and secondary insomnia due to significant chronic pain.. Treatment to date has included pain medication, oral Non-steroidal anti-inflammatory drug, muscle relaxants, topical gels, home exercises, urine toxicology testing, and Magnetic resonance imaging of left shoulder on December 17, 2014. Currently, the injured worker complains of low back pain with radiation greater on the left side than the right, worsened over the last few weeks with a lot of numbness and difficulty with activities of daily living, neck pain with radiation to both shoulders, bilateral shoulder pain, pain occasionally radiates down both upper extremities pain has recently worsened and she has difficulty lying on either side and raising arms above shoulder level, bilateral wrist and hand pain/numbness, right greater than left, bilateral ankle and foot pain, dental complaints related to dry mouth as a side effect of medication insomnia and depression due to pain. On December 23, 2014 Utilization Review non-certified a Norco 10/325 quantity 180, Flexeril 7.5mg quantity 60, Omeprazole 20mg quantity 60 and Intermezzo 1.75mg quantity 30, noting, Medical Treatment Utilization Schedule Guidelines , American College of

Occupational and Environmental Medicine and Official Disability Guidelines was cited. On December 16, 2014, the injured worker submitted an application for IMR for review of Norco 10/325 quantity 180, Flexeril 7.5mg quantity 60, Omeprazole 20mg quantity 60, Lorazepam 2mg quantity 30 and Intermezzo 1.75mg quantity 30.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Norco 10/325mg #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

**Decision rationale:** Norco 10/325mg #180 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that a satisfactory response to opioid treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation submitted reveals that the patient has been on long term opioids without significant functional improvement and persistent pain which is causing insomnia and depression. The MTUS also advises monitoring the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drugtaking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. The documentation indicates that the opioids are causing xerostomia with dental issues. Without evidence of significant efficacy of opioids and due to adverse side effects the request for continued Norco is not medically necessary.

**Flexeril 7.5mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42 and 64.

**Decision rationale:** Flexeril 7.5mg #60 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that Flexeril is not recommended to be used for longer than 2-3 weeks. The documentation indicates that the patient has already been on Flexeril (dating back to 9/26/14). There is no evidence of functional improvement from prior use. There are no extenuating circumstances documented that would necessitate continuing this medication beyond the 2-3 week time frame. The request for continued Flexeril is not medically necessary.

**Intermezzo 1.75mg #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.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS.

Decision based on Non-MTUS Citation

<http://www.intermezzorx.com/hcp/index.aspx><http://app.purduepharma.com/xmlpublishing/pi.aspx?id=i#section-4.2>.

**Decision rationale:** Intermezzo 1.75mg #30 is not medically necessary per the ODG and an online review of this medication. The MTUS Guidelines do not address insomnia or Intermezzo. A review online indicates that Intermezzo is the sublingual form of Zolpidem. A review of Intermezzo prescribing information states that sleep disturbances may be the presenting manifestation of a physical and/or psychiatric disorder, symptomatic treatment of insomnia should be initiated only after a careful evaluation of the patient. The failure of insomnia to remit after 7 to 10 days of treatment may indicate the presence of a primary psychiatric and/or medical illness that should be evaluated. The ODG states Zolpidem is approved for the short-term treatment of insomnia. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, 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. The Intermezzo prescribing guide states that intermezzo is indicated for use as needed for the treatment of insomnia when a middle-of-the-night awakening is followed by difficulty returning to sleep. Intermezzo is not indicated for the treatment of middle-of-the-night insomnia when the patient has fewer than 4 hours of bedtime remaining before the planned time of waking. The documentation is not clear on the patient's sleep pattern. The treatment plan and quantity are greater than the 7-10 day trial for this medication. The ODG does not recommend this medication long term. The documentation indicates the patient has depression which can be exacerbated with this medication. For all of these reasons Intermezzo 1.75mg #30 is not medically necessary.