

<b>Case Number:</b>	CM15-0107770		
<b>Date Assigned:</b>	06/12/2015	<b>Date of Injury:</b>	07/13/2005
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	05/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/04/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 53 year old female who sustained an industrial injury on 7/13/05. The injured worker was diagnosed as having lumbar degenerative disc disease, lumbar radiculopathy and lumbar spondylosis. Currently, the injured worker was with complaints of low back pain with radiation to the lower extremities. Previous treatments included medication management. The injured workers pain level was noted as 8/10. Medications diminish pain down to 4/10 and allow for ADLs such as shopping and cleaning. Physical examination was notable for bilateral straight leg raises with numbness in bilateral legs, decreased sensation, decreased range of motion and noted paraspinal tenderness. The plan of care was for medication prescriptions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hysingla ER (extended release) 40 mg [brand name] Qty 30, 1 tab every 24 hs (30 day supply):** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80. Decision based on Non-MTUS Citation Official Disability Guidelines, Hysingla.

**Decision rationale:** MTUS Guidelines support the use of opioids when there is meaningful pain relief, functional support and the lack of drug related behaviors. This individual has been on long term Morphine Sulfate and Norco with documented pain improvements of close to 50% and improved functioning. No aberrant behaviors are reported. Guidelines support the combination of a long acting and short acting opioid if there is support for opioid use associated with severe pain levels. This individual meets these criteria. The records sent for review do not include the records that document what a change in opioids was recommended, but Guidelines support opioid rotation and support Hysigla as a second line drug. Under these circumstances, the Hysingla ER (extended release) 40 mg [brand name] Qty 30, 1 tab every 24 hs (30 day supply) is supported by Guidelines and is medically necessary.

**Percocet 5/325 mg Qty 60 [brand name], oral tablet, 1 tablet every 12 hrs (30 day supply):**  
Overturned

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

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

**Decision rationale:** MTUS Guidelines support the use of opioids when there is meaningful pain relief, functional support and the lack of drug related behaviors. This individual has been on long term Morphine Sulfate and Norco with documented pain improvements of close to 50% and improved functioning. No aberrant behaviors are reported. Guidelines support the combination of a long acting and short acting opioid if there is support for opioid use associated with severe pain levels. This individual meets these criteria. The records sent for review do not include the records that document what a change in opioids was recommended, but Guidelines support opioid rotation. Under these circumstances, the Percocet 5/325 mg Qty 60 [brand name], oral tablet, 1 tablet every 12 hrs (30 day supply) is supported by Guidelines and is medically necessary.

**Ativan 1 mg Qty 30 [brand name], oral tab, 1 tab once daily (at bedtime), 30 day supply:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines, Insomnia treatment.

**Decision rationale:** MTUS Guidelines are very specific with the recommendation that benzodiazepine use be short term only. ODG Guidelines provide additional information

regarding appropriate insomnia treatment and the use of benzodiazepines are not recommended for this purpose. There are no unusual circumstances to justify an exception to Guidelines. The Ativan 1 mg Qty 30 [brand name], oral tab, 1 tab once daily (at bedtime), 30 day supply is not supported by Guidelines and is not medically necessary.