

<b>Case Number:</b>	CM15-0018422		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	04/22/2002
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	12/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2015

### 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: New York  
 Certification(s)/Specialty: Anesthesiology

### 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 male, who sustained an industrial injury on 04/22/2002. On provider visit dated 12/23/2014 the injured worker has reported right knee and thigh pain. On examination he was noted to have right knee pan with mild crepitus, lumbar range of motion was noted to be decreased, and straight-leg raise the injured worker felt pain in back and legs. The diagnoses have included lumbar surgeries, right lumbar spine radiculopathy and chronic pain syndrome. Treatment plan included medication, x-rays, and injections. On 12/30/2014, Utilization Review non-certified Ambien CR 12.5mg # 30, Benzepiril HCL 20mg # 30, Sertraline HCL 50mg # 30, MSER 60mg # 90, Fentanyl Patch 20mcg # 10, Translaminar L5/S1 epidural steroid injection, and Bilateral facet joint injection. The CA MTUS, ACOEM and Chronic Pain Medical Treatment Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**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.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia treatment.

**Decision rationale:** Ambien CR 12.5 mg (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is recommended for short-term treatment of insomnia (two to six weeks). Ambien CR is indicated 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. This can be habit-forming, and may impair function and memory more than opioid analgesics. There is also concern that Ambien may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology, and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case, Ambien CR has been used for greater than 6 months. There is no documentation of any modification of sleep hygiene, no documentation of a sleep study, documentation of functional improvement or ability to return to work associated with the ongoing treatment with Ambien CR. CA MTUS guidelines do not support long-term, treatment with sleep/hypnotic medications. There is no documentation provided indicating medical necessity for Ambien CR. The requested medication is not medically necessary.

**Benzepiril HCL 20mg # 30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine 2014 Benzepiril HCL.

**Decision rationale:** Benzepiril (Lotensin) is a drug of the angiotensin-converting enzyme (ACE) inhibitor class used primarily in the treatment of hypertension, congestive heart failure and myocardial infarction. It also protects renal and retinal complications of diabetes. In this case, there has been no documentation of the patient's vital signs, or documentation indicating that his hypertension condition is related to his work related injuries. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

**Sertraline HCL 50mg # 30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Selective Serotonin Reuptake Inhibitors (SSRIs).

**Decision rationale:** Selective Serotonin re-uptake inhibitors (SSRIs), such as Sertraline, are not recommended as a treatment for chronic pain, but may have a role in treating secondary depression. Prescribing physicians should provide the indication for these medications. Selective

serotonin reuptake inhibitors (SSRIs), a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline, are controversial based on controlled trials. It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. More information is needed regarding the role of SSRIs and pain. SSRIs have not been shown to be effective for low back pain. In this case, there is no documentation of psychiatric symptoms or a psychiatric diagnosis. There is no documentation of medical need to continue the Sertraline. Medical necessity for the requested medication is not established. The requested medication is not medically necessary.

**MSER 60mg # 90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-07. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** According to ODG, chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added. According to ODG and MTUS, Morphine sulfate ER(MSER) is a long-acting opioid analgesic, and is in a class of drugs that has a primary indication to relieve symptoms related to pain. Opioid drugs are available in various dosage forms and strengths. They are considered the most powerful class of analgesics that may be used to manage both acute and chronic pain. These medications are generally classified according to potency and duration of dosage. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

**Fentanyl Patch 20mcg # 10:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Opioids for the treatment of chronic pain Page(s): 91-97.

**Decision rationale:** Fentanyl is an opioid analgesic with a potency of eighty times that of Morphine. According to ODG, chronic pain can have a mixed physiologic etiology of both

neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added. According to ODG and MTUS, Fentanyl is a long-acting opioid analgesic, and is in a class of drugs that has a primary indication to relieve symptoms related to pain. Opioid drugs are available in various dosage forms and strengths. They are considered the most powerful class of analgesics that may be used to manage both acute and chronic pain. These medications are generally classified according to potency and duration of dosage. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. In addition, the patient's current opioid dosage is twice the maximum recommended, as he has been prescribed the Fentanyl patch and MSER. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

**Translaminar L5/S1 epidural steroid injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS (2009), Epidural Steroid Injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Epidural Steroid Injections (ESIs).

**Decision rationale:** Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. Research has shown that, on average, less than two injections are required for a successful ESI outcome. Epidural steroid injections can offer short-term pain relief and use should be in conjunction with other rehab efforts. The purpose of ESIs is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. CA MTUS guidelines state radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Other criteria for ESIs include, no more than 2 nerve root levels to be injected using transforaminal blocks, or more than one (1) intralaminar level injected per session. In this case, there are no objective findings on physical exam or corroborating diagnostic findings of radiculopathy. MTUS and ODG guidelines do not support treatment with lumbar ESIs in the absence of radiculopathy. Medical necessity for the

requested service has not been established. The requested translaminar L5/S1 epidural steroid injection is not medically necessary.

**Bilateral facet joint injection (unknown level): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines, online, 4th Edition.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Facet Blocks.

**Decision rationale:** MTUS/ACOEM guidelines do not support facet injections, blocks or nerve branch ablations in the management of injuries to the back. The guidelines provide very limited support for facet nerve blocks for treatment of low back injuries. Criteria for the use of diagnostic blocks for facet mediated pain include: (1) one set of diagnostic medial branch blocks with a response of greater than or equal to 70%; (2) limited to patients with low back pain that is non-radicular and at no more than two levels bilaterally; (3) there is documentation of failure of conservative treatment prior to the procedure for at least 4-6 weeks; and (4) no more than 2 facet joint levels are injected in one session. In this case, there are no objective physical exam findings of facet-medicated pain. In addition, there is no documentation indicating the level for the requested injection. Medical necessity for the requested service has not been established. The requested service is not medically necessary.