

<b>Case Number:</b>	CM15-0143840		
<b>Date Assigned:</b>	08/04/2015	<b>Date of Injury:</b>	07/24/2000
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	07/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2015

### 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: Physical Medicine & Rehabilitation

### 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 male, who sustained an industrial injury on July 24, 2000, incurring lower back, right knee, right leg, neck, and right shoulder injuries after a forklift accident. He was diagnosed with lumbar degenerative disc disease, lumbar spinal stenosis and right shoulder rotator cuff tear. He underwent multiple lumbar fusions. Treatment included physical therapy, acupuncture, pain medications, anti-inflammatory drugs, spinal cord stimulator, Cognitive Behavioral Therapy, and activity restrictions. Currently, the injured worker complained of chronic low back pain radiating into the lower extremities. He complained of right shoulder pain with reduced range of motion. He noted difficulty raising his arm and difficulty walking due to the persistent pain. He used a wheelchair for mobility but presently was unable to use the manual wheelchair. The treatment plan that was requested for authorization included prescriptions for Norco, Nucynta, Ambien and Toradol.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg quantity 240:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 76-78, 88,89.

**Decision rationale:** The patient was injured on 07/24/00 and presents with low back pain. The request is for NORCO 10/325 MG QUANTITY 240 for pain. The RFA is dated 07/07/15 and the patient is permanent and stationary. The patient has been taking this medication as early as 02/03/15 and treatment reports are provided from 02/03/15 to 06/16/15. MTUS Guidelines pages 88 and 89 under Criteria for Use of Opioids (Long-Term Users of Opioids): "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 under Criteria For Use of Opioids. Therapeutic Trial of Opioids 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. MTUS Guidelines, under Opioids For Chronic Pain, pages 80 and 81 state the following regarding chronic low back pain: "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." Long-term use of opiates may be indicated for nociceptive pain as it is Recommended as the standard of care for treatment of moderate or severe nociceptive pain (defined as pain that is presumed to be maintained by continual injury with the most common example being pain secondary to cancer). However, this patient does not present with pain that is "presumed to be maintained by continual injury." The 03/04/15 report states that the patient is "able to cook for himself." He rates his pain as a 5/10 with a frequency of 50-90%. The 06/16/15 report indicates that the CURES report was reviewed. In this case, not all of the 4 A's are addressed as required by MTUS Guidelines. Although there is a general pain scale provided, there are no before and after medication pain scales. There is only one example of an ADL, which is not sufficient documentation to demonstrate medication efficacy. There are no discussions provided on adverse behavior/side effects, no validated instruments are used, and no outcome measures provided as required by MTUS Guidelines. There are no urine drug screens provided to see if the patient is compliant with his prescribed medications. The treating physician does not provide adequate documentation that is required by MTUS Guidelines for continued opiate use. Therefore, the requested Norco IS NOT medically necessary.

**Nucynta 100mg quantity 180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60,61, 76-78, 88,89, 80,81.

**Decision rationale:** The patient was injured on 07/24/00 and presents with low back pain. The request is for NUCYNTA 100 MG QUANTITY 180 for pain. The RFA is dated 07/07/15 and the patient is permanent and stationary. The patient has been taking this medication as early as 02/03/15 and treatment reports are provided from 02/03/15 to 06/16/15. MTUS Guidelines pages 88 and 89 under Criteria for Use of Opioids (Long-Term Users of Opioids): "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 under Criteria For Use of Opioids. Therapeutic Trial of Opioids 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. MTUS Guidelines, under Opioids For Chronic Pain, pages 80 and 81 state the following regarding chronic low back pain: Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. "Long-term use of opiates may be indicated for nociceptive pain as it is "Recommended as the standard of care for treatment of moderate or severe nociceptive pain (defined as pain that is presumed to be maintained by continual injury with the most common example being pain secondary to cancer)." However, this patient does not present with pain that is "presumed to be maintained by continual injury." The 03/04/15 report states that the patient is "able to cook for himself." He rates his pain as a 5/10 with a frequency of 50-90%. The 06/16/15 report indicates that the CURES report was reviewed. In this case, not all of the 4 A's are addressed as required by MTUS Guidelines. Although there is a general pain scale provided, there are no before and after medication pain scales. There is only one example of an ADL, which is not sufficient documentation to demonstrate medication efficacy. There are no discussions provided on adverse behavior/side effects, no validated instruments are used, and no outcome measures provided as required by MTUS Guidelines. There are no urine drug screens provided to see if the patient is compliant with his prescribed medications. The treating physician does not provide adequate documentation that is required by MTUS Guidelines for continued opiate use. Therefore, the requested Nucynta IS NOT medically necessary.

**Ambien 10mg quantity 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, Zolpidem (Ambien).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, under Zolpidem (Ambien).

**Decision rationale:** The patient was injured on 07/24/00 and presents with low back pain. The request is for AMBIEN 10 MG QUANTITY 30 for sleep. The RFA is dated 07/07/15 and the patient is permanent and stationary. The patient has been taking Ambien as early as 04/20/15. MTUS and ACOEM Guidelines are silent with regard to his request. However, ODG Guidelines, Mental Illness and Stress Chapter, under Zolpidem (Ambien) states, "Zolpidem (Ambien, generic available, Ambien CR) is indicated for short term use of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Long-term studies have found Ambien CR to be effective for up to 24 weeks in adults. The patient has radicular pain along L3-4, L4-5, and L5-S1, a decreased range of motion of the lumbar spine, a positive straight leg raise, a decreased range of motion of the right shoulder, and tenderness to palpation at the AC joint. He is diagnosed with lumbar degenerative disc disease, lumbar spinal stenosis and right shoulder rotator cuff tear. ODG Guidelines support the use of Zolpidem for 7 to 10 days for insomnia. In this case, the patient has been taking Ambien since 04/20/15, which exceeds the 7-10 days recommended by ODG Guidelines. Furthermore, none of the reports provided mention if the patient has insomnia or any difficulty sleeping. The requested Ambien IS NOT medically necessary.

**Toradol 60mg IM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs Page(s): 72.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 72.

**Decision rationale:** The patient was injured on 07/24/00 and presents with low back pain. The request is for TORADOL 60 MG IM. The RFA is dated 07/07/15 and the patient is permanent and stationary. The patient has had prior Toradol injections on 02/03/15 and 06/16/15. MTUS Guidelines, Injectable Ketorolac vs. Oral Ibuprofen- NSAIDs, specific drug list & adverse effects, page 72 states that "this medication is not indicated for minor or chronic painful conditions." Academic Emergency Medicine, Vol 5, 118-122, Intramuscular ketorolac vs. oral ibuprofen in emergency department patients with acute pain, study demonstrated that there is "no difference between the two and both provided comparable levels of analgesia in emergency patients presenting with moderate to severe pain." The patient has radicular pain along L3-4, L4-5, and L5-S1, a decreased range of motion of the lumbar spine, a positive straight leg raise, a decreased range of motion of the right shoulder, and tenderness to palpation at the AC joint. He is diagnosed with lumbar degenerative disc disease, lumbar spinal stenosis and right shoulder rotator cuff tear. The patient had a prior Toradol injection; however, none of the reports provided indicate how long prior injections provided relief and a reduction in medication is not apparent. The reason for the request is not provided. There is lack of any support from the guidelines for the use of this medication for chronic pain. Oral Ibuprofen appears as good as IM Toradol for acute pain according to one study. The requested Toradol injection IS NOT medically necessary.