

<b>Case Number:</b>	CM15-0184477		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	03/26/2008
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	09/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2015

### 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, 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 64 year old male who sustained an industrial injury on 03-26-2008. According to a progress report dated 08-14-2015, the injured worker continued to have ongoing pain in his lower back radiating down to both lower extremities, left greater than right. Pain could go as high as 7 on a scale of 1-10 in intensity. With current medical regimen, it decreased to 5. He relied on his lumbar spinal cord stimulator which was implanted on 08-08-2013 and reported at least 50% pain relief to his lower back and radicular symptoms to his lower extremities. He also responded to trigger point injections that provided about 2-3 weeks of pain relief greater than 50% with the ability to increase his range of motion and activities of daily living. Over the last four to six months, the spinal cord stimulator IPG had been expiring. He had to recharge much more frequently. The rate had been turned down to try and conserve battery life, but the IPG was progressively getting worse indicating that it was expiring. He reported pain in both knees. The knees were not industrial related. He fell a week prior which exacerbated his back pain. The provider noted that the current oral analgesic medications enabled him to function on a daily basis. He was able to perform activities of daily living with less pain and able to perform simple chores around the house which included cooking and cleaning. He was currently on Duragesic 75 mcg and Percocet for breakthrough pain which he took two to three times a day. He reported about 30-40% pain relief and increased ability to perform activities of daily living with his Duragesic combined with Percocet, Neurontin and other medications listed. With medications, he was able to lose 30 pounds over the past four months since he had been actively participating in a home exercise program. He required Flexeril for myospasms to help him function better throughout the day. He was unable to sleep without Restoril which helped

him function better the next day. He had been recently diagnosed with atrial fibrillation and ruled out for an acute myocardial infarction. Medications included Duragesic 75 mcg every 2 days, Neurontin 600 mg four times a day, Percocet 10-325 mg three times a day as needed, Flexeril 10 mg twice a day as needed, Restoril 30 mg at bedtime, Tribayka 1 daily and Truvada 200 mg daily. Urine was qualitatively positive for benzodiazepines and opiates which was noted as consistent. Assessment included lumbar disc herniation with left lower extremity radiculopathy, right femoral neck fracture status post open reduction internal fixation on 03-27-2008, right knee internal derangement, right shoulder rotator cuff tear status post arthroscopic surgery 11-2008, adhesive capsulitis right shoulder status post arthroscopic surgery 08-2009, status post anterior lumbar interbody fusion L3-4 along with decompression of the left peroneal nerve on 09-2011, status post L1-2, L2-3, L3-4, L4-5 and L5-S1 posterior lumbar interbody fusion on 06-27-2012, lumbar spinal cord stimulator, medication induced gastritis and new onset of atrial fibrillation non-industrial. The treatment plan included trial a Nevro paresthesia free high frequency SCS system, trigger point injection, Duragesic 75 mcg #15, Percocet 10-325 mg #90. The injured worker had additional prescription refills for Neurontin, Flexeril and Restoril. He was to return in one month for a follow up. Records show use of Duragesic, Flexeril and Norco dating back to March 2015. On 05-15-2015 Percocet was prescribed for exacerbation of back and knee pain. A urine toxicology performed on 06-29-2015 was positive for Oxycodone, Noroxycodone, Oxymorphone, Temazepam, Oxazepam and Acetaminophen. On 09-01-2015, Utilization Review non-certified the request for Percocet 10-325 mg #90, Duragesic 75 mg #15, Flexeril 10 mg (quantity specified), Restoril 30 mg (quantity unspecified) and authorized the request for 1 paresthesia free ultra high frequency SCS system by Nevro and 1 follow up in one month.

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

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

#### **Percocet 10/325mg #90: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids (Classification), Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment.

**Decision rationale:** Regarding the request for Percocet 10/325mg #90, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's function and pain with no intolerable side effects or aberrant use, and the

patient is noted to undergo monitoring. In light of the above, the currently requested Percocet 10/325mg #90 is medically necessary.

**Duragesic 75mg #15:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment.

**Decision rationale:** Regarding the request for Duragesic 75mg #15, California Pain Medical Treatment Guidelines note that it is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the medication is improving the patient's function and pain with no intolerable side effects or aberrant use, and the patient is noted to undergo monitoring. In light of the above, the currently requested Duragesic 75mg #15 is medically necessary.

**Flexeril 10mg (quantity unspecified):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** Regarding the request for cyclobenzaprine (Flexeril), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Furthermore, there is no documentation of failure of first-line treatment options, as recommended by guidelines. Additionally, this request does not include a quantity or duration of use. Guidelines do not support the open-ended application of any medication and there is no provision to modify the current request. As such, the currently requested cyclobenzaprine (Flexeril) is not medically necessary.

**Restoril 30mg (quantity unspecified): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic): Insomnia treatment (2015).

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

**Decision rationale:** Regarding the request for temazepam (Restoril), Chronic Pain Medical Treatment Guidelines state the benzodiazepines are "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant." ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there is no description of the patient's sleep complaints, failure of behavioral treatment, response to medication, etc. Additionally, this request does not include a quantity or duration of use. Guidelines do not support the open-ended application of any medication and there is no provision to modify the current request. As such, there is no clear indication for use of this medication. In light of the above issues, the currently requested temazepam (Restoril) is not medically necessary.