

<b>Case Number:</b>	CM15-0185910		
<b>Date Assigned:</b>	10/05/2015	<b>Date of Injury:</b>	01/08/2013
<b>Decision Date:</b>	12/08/2015	<b>UR Denial Date:</b>	09/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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: Internal 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 59 year old female, who sustained an industrial injury on January 08, 2013. The injured worker was diagnosed as having acute and chronic pain, herniated nucleus pulposus at lumbar four to five with lumbar five neural impingement, status post epidural steroid injection of the facet injections, status post two sacroiliac joint injections, status post two caudal injections, and status post rhizotomy. Treatment and diagnostic studies to date has included use of a transcutaneous electrical nerve stimulation unit, x-rays, computed tomography, magnetic resonance imaging of the lumbar spine, electromyogram, ultrasound, medication regimen, physical therapy, acupuncture, and water exercises. In a progress note dated August 22, 2015 the treating physician reports dull to sharp pain to the left lumbar spine, left thigh, left lateral foot pain, and left popliteal area. Examination performed on August 22, 2015 was revealing for decreased motor strength to the left lower extremity, decreased sensation to the left lower extremity at lumbar two to three and lumbar four through sacral one, weak reflexes to the bilateral upper and lower extremities, tenderness to the left lumbar paralumbar muscles, and decreased range of motion to the lumbar spine. The injured worker's medication regimen on August 22, 2015 included Norco (since at least February of 2015), Clonazepam (since at least April of 2015), Percocet (start of medication unknown), Lorazepam (since at least February of 2015), and Flexeril (since at least February of 2015). The injured worker's current pain level on August 22, 2015 was rated a 5 to 6 out of 10 and noted that the injured worker's pain level was a 10 out of 10 60% of the time, but decreases to a 2 out of 10 with the use of a transcutaneous electrical nerve stimulation unit. On August 22, 2015 the treating physician requested Norco 10-

325 mg with a quantity of 120, Percocet 10-325mg with a quantity of 90, and Flexeril 10mg with a quantity of 90 noting current use of these medications. The treating physician also requested the medication of Ambien 10mg with quantity of 30 for insomnia, but the progress note did not include any documentation on sleep disturbances. On September 06, 2015 the Utilization Review determined the request for Norco 10-325 mg with a quantity of 120 to be modified. On September 06, 2015 the Utilization Review determined the request for Percocet 10-325mg with a quantity of 90, Flexeril 10mg with a quantity of 90, and Ambien 10mg with a quantity of 30 to be non-certified.

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

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

**Norco 10/325 mg Qty 120:** Upheld

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

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

**Decision rationale:** MTUS recommends that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects must be documented with the use of Opioids. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guidelines recommend using key factors such as pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors, to monitor chronic pain patients on opioids. Assessment for the likelihood that the patient could be weaned from opioids is recommended if there is no overall improvement in pain or function, unless there are extenuating circumstances and if there is continuing pain with the evidence of intolerable adverse effects. The injured worker's pain is chronic and ongoing, with subjective report of some decrease with the use of a transcutaneous electrical nerve stimulation unit. Documentation fails to demonstrate adequate objective improvement in level of function or pain, to support the medical necessity for continued use of opioids. In the absence of significant response to treatment, the request for Norco 10/325 mg Qty 120 is not medically necessary.

**Percocet 10/325 mg Qty 90:** Upheld

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

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

**Decision rationale:** MTUS recommends that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects must be documented with the use of Opioids. Satisfactory response to treatment may be indicated by the patient's decreased pain,

increased level of function, or improved quality of life. Guidelines recommend using key factors such as pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors, to monitor chronic pain patients on opioids. Assessment for the likelihood that the patient could be weaned from opioids is recommended if there is no overall improvement in pain or function, unless there are extenuating circumstances and if there is continuing pain with the evidence of intolerable adverse effects. The injured worker's pain is chronic and ongoing, with subjective report of some decrease with the use of a transcutaneous electrical nerve stimulation unit. Documentation fails to demonstrate adequate objective improvement in level of function or pain, to support the medical necessity for continued use of opioids. In the absence of significant response to treatment, the request for Percocet 10/325 mg Qty 90 is not medically necessary.

**Flexeril 10 mg Qty 90:** 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:** Cyclobenzaprine (Flexeril) is a skeletal muscle relaxant and a central nervous system depressant recommended as a treatment option to decrease muscle spasm in conditions such as low back pain. Per MTUS guidelines, muscle relaxants are recommended for use with caution as a second-line option for only short-term treatment of acute exacerbations in patients with chronic low back pain. The greatest effect appears to be in the first 4 days of treatment and appears to diminish over time. Documentation fails to indicate clinical findings of muscle spasm or significant objective improvement in the injured worker's pain or functional status to justify continued use of Flexeril. The request for Flexeril 10 mg Qty 90 is not medically necessary per MTUS guidelines.

**Ambien 10 mg Qty 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: Pain - 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) Pain Chapter, Insomnia treatment.

**Decision rationale:** MTUS does not address this request. Zolpidem is a prescription short-acting non-benzodiazepine hypnotic, used for treatment of insomnia. Per guidelines, hypnotics are not recommended for long-term use and should be limited to three weeks maximum in the first two months of injury only. Use in the chronic phase is discouraged. 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 injured worker

has chronic pain with no documented symptoms of sleep disorder. Physician report indicates Ambien is prescribed for Insomnia, but there is lack of report regarding details of the effect of the injured worker's pain on quality of sleep. The medical necessity for the use of Ambien has not been established. Per guidelines, the request for Ambien 10 mg Qty 30 is not medically necessary.