

<b>Case Number:</b>	CM15-0030004		
<b>Date Assigned:</b>	02/23/2015	<b>Date of Injury:</b>	04/27/1991
<b>Decision Date:</b>	04/10/2015	<b>UR Denial Date:</b>	01/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2015

### 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: 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 52-year-old female, who sustained an industrial injury on 4/27/1991. The current diagnoses are status post L4-5 fusion with hardware removal, lumbar radiculopathy, and spasm of muscle, feet pain, and insomnia. Currently, the injured worker complains of persistent back pain with radiation to bilateral lower extremities, left greater than right. She describes the pain as sharp, numbness and tingling, and pins and needles on the left foot. The pain is rated 8/10 with medications and 10/10 without. Current medications are Norco, Flexeril, Neurontin, Lidoderm patch, and Ambien. The physical examination revealed increased tenderness and spasm of the thoracic and lumbar paraspinal muscles. Range of motion of the lumbar spine was decreased. Motor examination is 4/5 in the left lower extremity. There is decreased sensation to light touch in the bilateral posterior lower extremities, left worse than right. There are decreased deep tendon reflexes in the left heel. Treatment to date has included medications, epidural steroid injection (8/14/2014), and surgery. The treating physician is requesting Norco 10/325mg #180, Neurontin 600mg #180, Ambien 10mg #30, Flexeril 10mg #20, and Sprix nasal spray #5, which is now under review. On 1/28/2015, Utilization Review had non-certified a request for Norco 10/325mg #180, Neurontin 600mg #180, Ambien 10mg #30, Flexeril 10mg #20, and Sprix nasal spray #5. The California MTUS Chronic Pain and Official Disability Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg twice a day, #180:** Upheld

**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): 91-97.

**Decision rationale:** According to MTUS and ODG, Norco (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. 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, the patient complains of persistent back pain with radiculopathy. Pain is rated 8/10 with medications and 10/10 without medications. However, there is no documentation of objective functional benefit with this medication use or an updated and signed pain contract between the provider and the patient, as required by CA MTUS. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

**Neurontin 600mg twice a day, #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs (AEDs), Gabapentin (Neurontin) Page(s): 17-19, 49.

**Decision rationale:** According to the CA MTUS (2009) and ODG, Gabapentin (Neurontin) is an anti-epilepsy drug (AED), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. This medication appears to be effective in reducing abnormal hypersensitivity (allodynia and hyperalgesia), to have anti-anxiety effects, and may be beneficial as a sleep aid. In addition, there is limited evidence to show that this medication is effective for postoperative pain. In this case, there is no documentation of objective functional benefit with Gabapentin. Medical necessity of the requested medication has not been established. The requested item is not medically necessary.

**Ambien 10mg as needed #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 - TWC Pain Procedure Summary, 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) Insomnia Treatment.

**Decision rationale:** Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Proper sleep hygiene is critical to the individual with chronic pain, and often is hard to obtain. Ambien 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, there is no clear documentation of sleep history. There is no documentation of objective functional improvement with this medication use. In addition, Ambien is not recommended for long-term use. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

**Flexeril 10mg three times a day #20:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Procedure Summary, Non-sedating muscle relaxants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

**Decision rationale:** Flexeril (Cyclobenzaprine) is a skeletal muscle relaxant and a central nervous system (CNS) depressant with similar effects to tricyclic antidepressants. It has a central mechanism of action, but it is not effective in treating spasticity from cerebral palsy or spinal cord disease. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. Flexeril is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. In addition, this medication is not recommended to be used for longer than 2-3 weeks. In this case, there are no muscle spasms documented on physical exam. There is no documentation of objective functional improvement from any previous use of this medication. Based on the currently available information, the medical necessity for Flexeril has not been established. The requested medication is not medically necessary.

**Sprix nasal spray #5:** 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 Procedure Summary, Ketorolac Tromethamine (Sprix Nasal Spray).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-71. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ketorolac Tromethamine, Sprix Nasal Spray.

**Decision rationale:** In May 2010, FDA approved an intranasal formulation of Ketorolac Tromethamine (Sprix Nasal Spray) for the short-term management of moderate to moderately severe pain requiring analgesia at the opioid level. The total duration of use of this intranasal formulation, as with other Ketorolac (Toradol) formulations, should be for the shortest duration possible and not exceed 5 days. Both studies used for approval were for short-term pain relief after abdominal surgery, so this nasal spray it is not recommended as a first-line medication for chronic pain. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. Medical necessity of the nasal spray has not been established. The requested medication is not medically necessary.