

<b>Case Number:</b>	CM15-0033885		
<b>Date Assigned:</b>	02/27/2015	<b>Date of Injury:</b>	03/29/2004
<b>Decision Date:</b>	05/19/2015	<b>UR Denial Date:</b>	02/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/23/2015

### 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: Pediatrics, 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 50-year-old female, who sustained an industrial injury on 3/29/2004. The diagnoses have included cervical spinal stenosis, cervical herniated disc, lumbar herniated disc, lumbar radiculopathy and knee osteoarthritis. Treatment to date has included medication. According to the progress report dated 2/3/2015, the injured worker complained of neck pain rated 9/10 and radiating to the bilateral upper extremities. The injured worker complained of low back pain rated 10/10 and radiating into the bilateral lower extremities. The injured worker complained of left knee pain rated 7/10 and right hip pain rated 9/10. The injured worker reported that pain was relieved by nothing. Physical exam revealed tenderness to palpation over the cervical spine and over the lumbar facet area. The injured worker was to be scheduled for epidural steroid injections (ESI). A random urine drug screen was to be obtained. It was noted that pain control was suboptimal with current medications. Treatment plan was to renew Neurontin, Soma, topical cream and patches, discontinue Butrans patch and prescribe Percocet and Ambien. On 2/12/2015, Utilization Review (UR) non-certified requests for Soma 350mg #90, Neurontin 300mg #90, Percocet 10/325mg #120, Ambien 10mg #30 and a urine toxicology test. The Medical Treatment Utilization Schedule (MTUS) and Official Disability Guidelines (ODG) were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Soma 350mg one (1) three times a day #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

**Decision rationale:** Not recommended, this medication is not indicated for long-term use. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. The request is not medically necessary and appropriate.

**Neurontin 300mg one (1) three times a day #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 18.

**Decision rationale:** AED's are not recommended, as there is a lack of evidence to demonstrate that AEDs significantly reduce the level of myofascial or other sources of somatic pain. There is no notation in the records provided that the IW had clinical evident neuropathy related to her degenerative disc disease. The Neurontin is not medically necessary.

**Percocet 10/325mg one (1) every 6 hours #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Criteria for use of Opioids 4) On-Going Management Page(s): 78.

**Decision rationale:** Ongoing use of an opioid should include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. The medical records provided do not clearly document decreased pain, increased activities and lack of adverse reactions. This request is not medically necessary and appropriate.

**Ambien 10mg one (1) every night at bedtime #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 (ODG) Integrated Treatment/Disability Duration Guidelines, Stress & Mental Illness Chapter.

**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:** Per ODG, pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. Ambien is indicated for the short-term treatment 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. There is no discussion of an investigation into the origin of the sleep disturbance and non-pharmacological interventions that may have been utilized. Additionally, the dose requested is not appropriate as Ambien is dosed at 5 or 10 mg nightly. This request is not medically necessary.

**Urine toxicology test:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines drug testing, Opioids, screening for risk of addiction (tests) Page(s): 78-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, pain treatment agreement Page(s): 89.

**Decision rationale:** According to MTUS guidelines, IW's treated with opioids may be required to sign a pain treatment agreement. Part of the agreement may include urine screening for medication and illicit substances. No pain management agreement was submitted stating urinalysis was required and there was no notation of irregular behavior suggesting abuse. This request is not medically necessary and appropriate.