

<b>Case Number:</b>	CM15-0055183		
<b>Date Assigned:</b>	03/30/2015	<b>Date of Injury:</b>	12/30/2009
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	03/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/23/2015

### 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: Pennsylvania  
 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 68 year old male who has reported low back and lower extremity pain after moving boxes on 12/30/2009. The injured worker was diagnosed with status post T12-S1 fusion, chronic lumbar radiculopathy, lumbar post laminectomy syndrome with intractable pain, and diabetes. Treatment to date has included medications, injections, physical therapy, and multiple spine surgeries. The most recent surgery was a lumbar revision fusion on 1/23/15. Hydrocodone was started in 2010. Treating physician reports since 2011 show ongoing use of Butrans, Percocet, Flexeril, Doxepin, and Ambien. Non-specific pain relief and functional improvement was reported with unspecified medications as a group. None of the reports from the pain management physician describe significant symptomatic and functional benefit from any specific medication. The reports infrequently mention the medication beyond stating that it is used and will be refilled. Per the report of 2/18/15 from the pain management physician, there was 8/10 pain. Sleep was poor. He takes Percocet 8/day and Butrans. Medications were refilled. There was no discussion of the specific results of using any medication. There was no discussion of functional results of treatment. The injured worker was using an electric wheelchair. The treatment plan consisted of physical therapy, medication refills (Butrans, Percocet, Flexeril, Ambien, Doxepin 100mg, and Doxepin 25mg), and follow up in one month. These medications were requested in the Request for Authorization of 3/13/15. Per the surgeon report of 3/2/15 the injured worker appeared intoxicated. He was ambulating well and also had an electric scooter. He was prescribed Butrans, Percocet #150, and Lyrica. On 3/14/15 Utilization Review non-certified Butrans, Percocet, Flexeril, and Ambien. Doxepin was certified. Note was made of a

very recent prescription for Butrans that was certified on 3/11/15. Percocet had been prescribed since 2011 with minimal functional improvement. Ambien and Flexeril had been prescribed since 2011 without significant improvement.

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

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

**Butrans patch 20mcg #4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid management, Opioids, steps to avoid misuse/addiction, indications, Chronic back pain, Mechanical and compressive etiologies, Medication trials, Buprenorphine Page(s): 77-81, 94, 80, 81, 60, 26.

**Decision rationale:** There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opioid contract, and there should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. The injured worker has been given opioids for years, with no evidence of any treatment plans that attempted to use other means of analgesia. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. There is no evidence of significant pain relief or increased function from the opioids used to date. None of the reports address work status or specific functions in relation to opioids. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is a high rate of aberrant opioid use in patients with chronic back pain. There is no record of a urine drug screen program. The records show that this injured worker is receiving opioids from more than one physician in the very recent past. The MTUS recommends that patients receive their medication from one physician and one pharmacy only. There is no evidence that either of the prescribing physicians was aware that this was occurring. Buprenorphine has agonist and antagonist actions. It will block the effect of other agonist opioids. It is not clear why it has been prescribed along with a pure agonist opioid. As currently prescribed, this opioid does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

**Percocet 10/325mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Oxycodone/Acetaminophen.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioid management, Opioids, steps to avoid misuse/addiction, indications, Chronic back pain, Mechanical and compressive etiologies, Medication trials Page(s): 77-81, 94, 80, 81, 60.

**Decision rationale:** There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opioid contract, and there should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. The injured worker has been given opioids for years, with no evidence of any treatment plans that attempted to use other means of analgesia. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. There is no evidence of significant pain relief or increased function from the opioids used to date. None of the reports address work status or specific functions in relation to opioids. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is a high rate of aberrant opioid use in patients with chronic back pain. There is no record of a urine drug screen program. The records show that this injured worker is receiving opioids from more than one physician in the very recent past. The MTUS recommends that patients receive their medication from one physician and one pharmacy only. There is no evidence that either of the prescribing physicians was aware that this was occurring. This injured worker was also prescribed Buprenorphine. Buprenorphine has agonist and antagonist actions. It will block the effect of other agonist opioids. It is not clear why it has been prescribed along with a pure agonist opioid like Percocet. As currently prescribed, Percocet does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

**Flexeril 10mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, Cyclobenzaprine Page(s): 41-42, 63-66.

**Decision rationale:** The MTUS for Chronic Pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. This injured worker has chronic pain with no evidence of prescribing for flare-ups. Prescribing has occurred consistently for years. The quantity prescribed implies long term use, not a short period of use for acute pain. No reports show any specific and significant improvements in pain or function as a result of prescribing muscle relaxants. None of the reports discuss the specific results of using cyclobenzaprine. Cyclobenzaprine, per the MTUS, is indicated for short term use only and is not recommended in combination with other agents. This injured worker has been prescribed multiple medications along with cyclobenzaprine. Per the MTUS, this muscle relaxant is not indicated and is not medically necessary.

**Ambien 10mg, 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, Pain (Chronic), 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:** The MTUS does not address the use of hypnotics other than benzodiazepines. The Official Disability Guidelines were used instead. The Official Disability Guidelines recommend the short term use of hypnotics like zolpidem (less than two months), discuss the significant side effects, and note the need for a careful evaluation of the sleep difficulties. No physician reports describe the specific criteria for a sleep disorder. The treating physician has not addressed other major issues affecting sleep in this patient, including the use of other psychoactive agents like opioids, which significantly impair sleep architecture. None of the reports address the specific results of using Ambien. Sleep is described as poor in some reports, suggesting that Ambien is not beneficial. Note the ODG citation which recommends short term use of zolpidem, a careful analysis of the sleep disorder, and caution against using zolpidem in the elderly. Prescribing in this case meets none of the guideline recommendations. Zolpidem is not medically necessary based on prolonged use contrary to guideline recommendations, lack of benefit, and lack of sufficient evaluation of the sleep disorder.