

<b>Case Number:</b>	CM15-0058862		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	04/18/2001
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	03/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2015

### 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: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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:

This is a female injured worker ( [REDACTED] ) who reported an injury on 04/18/2001. The mechanism of injury was not specifically stated. The current diagnoses include lumbar failed back surgery syndrome, lumbar degenerative disc disease, bilateral lower extremities radiculopathy, chronic DVT, depression, insomnia, and constipation. The injured worker presented on 03/10/2015 for a follow-up evaluation with complaints of persistent low back pain. The injured worker stated she could not sit still or lie down for long periods of time. The provider indicated the injured worker was stable on the current medication regimen with consistent urine drug testing and no adverse effects. The injured worker was actively participating in a daily home exercise program. Upon examination, the injured worker appeared anxious with many pain behaviors observed. The injured worker demonstrated frequent position changes and full extension of the lumbar spine. A urine drug test was collected for review. The physician recommended a continuation of MS Contin 60 mg, Norco 10/325 mg, and Lunesta 3 mg. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MS Contin 60 mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the injured worker had utilizing the above medication since at least 01/2014. The injured worker continued to present with persistent pain and activity limitations. There was no documentation of objective functional improvement. There was also no evidence of a written consent or an agreement for the chronic use of an opioid. The request as submitted failed to indicate a frequency for the medication. Given the above, the request is not medically appropriate.

**Norco 10/325 mg #240:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, the injured worker had utilizing the above medication since at least 01/2014. The injured worker continued to present with persistent pain and activity limitations. There was no documentation of objective functional improvement. There was also no evidence of a written consent or an agreement for the chronic use of an opioid. The request as submitted failed to indicate a frequency for the medication. Given the above, the request is not medically appropriate.

**Lunesta 3 mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Med Lett drugs ther. 2005 17-9.

**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 Chapter, Insomnia Treatment.

**Decision rationale:** The Official Disability Guidelines recommend insomnia treatment based on etiology. Lunesta has demonstrated reduced sleep latency and sleep maintenance. In this case, it

was noted that the injured worker had continuously utilized the above medication since at least 01/2014. There was no documentation of a failure to respond to nonpharmacologic treatment for insomnia prior to the request for a prescription product. There was no mention of functional improvement despite the ongoing use of this medication. There was also no frequency listed in the request. As such, this request is not medically necessary.

**Flexeril 10 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, muscle relaxants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** The California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. There was no documentation of palpable muscle spasm or spasticity upon examination. The medical necessity for the use of the requested medication has not been established. There was also no frequency listed in the request. As such, this request is not medically necessary.

**Protonix 40 mg #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)-pain procedure summary.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** The California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. In this case, there was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The medical necessity for the requested medication has not been established. Additionally, there is no frequency listed in the request. As such, the request is not medically appropriate.

**Miralax:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-pain procedure summary.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Opioid induced constipation treatment.

**Decision rationale:** The California MTUS Guidelines recommended initiating prophylactic treatment of constipation when also initiating opioid therapy. The Official Disability Guidelines recommend opioid induced constipation treatment with first line treatment to include increasing physical activity, maintaining appropriate hydration, and advising the patient to follow a proper diet. There was no documentation of a failure of first line treatment prior to the initiation of a prescription product. There was no documentation of chronic constipation as evidenced by subjective complaints or functional improvement with the ongoing use of the above medication. The request as submitted failed to indicate the specific strength, frequency, or quantity. Given the above, the request is not medically appropriate.