

<b>Case Number:</b>	CM15-0087560		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	09/11/2003
<b>Decision Date:</b>	09/14/2015	<b>UR Denial Date:</b>	04/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/06/2015

### 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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 49 year old male, who sustained an industrial injury on 9/11/2003. Diagnoses have included displacement of lumbar intervertebral disc without myelopathy and thoracic or lumbosacral neuritis or radiculitis unspecified. Treatment to date has included lumbar spine surgeries, lumbar epidural steroid injection and medication. According to the progress report dated 1/20/2015, the injured worker complained of pain in the lower back on both sides and into the buttock. The pain was rated as a fairly severe flare over the last week non-responsive to conservative measures. The pain was relieved by stable baseline pain control on Fentanyl patch (same dose for multiple years) and transforaminal epidural injections in the past for similar flares of severe radicular pain. Objective findings showed significant muscle spasms in the lower back and tenderness to palpation. Straight leg raising was markedly positive right greater than left. There was decreased sensation in the lateral right greater than left leg. Gait was antalgic with a limp on the right side. The treatment plan was for bilateral L5 transforaminal epidural injections. Authorization was requested for Prilosec, Oxycodone, Fenoprofen, Flexeril, Fentanyl patches and Ambien.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Fenoprofen 400 mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

**Decision rationale:** As per MTUS Chronic Pain Guidelines, NSAIDs are useful for osteoarthritis related pain. Due to side effects, and risks of adverse reactions, MTUS recommends as low a dose as possible for as short a course as possible. The request as submitted fails to document duration or frequency. As such, at this time the request is not medically necessary.

**Fentanyl patch 75 mcg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management of pain.

**Decision rationale:** According to the California MTUS, ongoing pain medications can be considered if the 4 As have been established. The 4 As include analgesia, activities of daily living, aberrant drug taking behavior, and adverse side effects. There is no mention that the injured worker cannot tolerate oral forms of pain medications to treat his condition. There is no mention of monitoring for aberrant behavior, or adverse reactions. Duragesic is not a first line treatment for chronic pain. As such, at this time the medical necessity of this request cannot be substantiated.

**Prilosec 20 mg:** Upheld

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

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

**Decision rationale:** According to the MTUS Chronic Pain Guidelines, Proton Pump Inhibitors are used to treat symptoms of gastritis, peptic ulceration, acid reflux, and/or dyspepsia related to non-steroidal anti-inflammatories (NSAIDs). There is no mention of dyspepsia or any of the above mentioned diagnoses. The request for Fenopufen was deemed unnecessary and as such this request cannot be deemed medically necessary at present time.

**Oxycodone 10 mg for breakthrough pain:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Oxycodone Page(s): 75, 78.

**Decision rationale:** According to the California MTUS, ongoing pain medications can be considered if the 4 As have been established. The 4 As include analgesia, activities of daily living, aberrant drug taking behavior, and adverse side effects. There is no mention of monitoring for aberrant behavior, and no mention of dose frequency or duration in the request. This request cannot be supported at this time and therefore is not medically necessary.

**Ambien 10 mg:** 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 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) Ambien.

**Decision rationale:** According to the Official Disability Guidelines (ODG), Ambien is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. They are not recommended for long-term use. They can be habit-forming and impair function and memory more than opioid pain relievers. There is no mention of duration or frequency with this request. There is no mention of whether this injured worker has been on Ambien in the past and if this was effective. As such, this request is not medically necessary at this time.

**Flexeril 7.5 mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines anti-spasticity drugs.

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

**Decision rationale:** According to the California MTUS Chronic Pain Guidelines, in regards to Flexeril it is stated that "This medication is not recommended to be used for longer than 2-3 weeks." There is no mention of dose frequency or duration. As such, this request is not medically necessary.