

<b>Case Number:</b>	CM15-0087857		
<b>Date Assigned:</b>	05/12/2015	<b>Date of Injury:</b>	08/04/2011
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	04/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2015

### 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: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational 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 46 year old female, who sustained an industrial injury 08/04/2011. On provider visit dated 03/17/2015 the injured worker has reported chronic thoracolumbar pain with left sciatic pain and left shoulder pain. On examination the spine, there was tenderness noted throughout the left paraspinal musculature throughout the spine. Decreased range of motion was noted. Straight leg raise was noted to be negative bilaterally. MRI of the lumbar spine was noted to have small left L4-L5 disc protrusion with lateral recess stenosis, left L5-S1 foraminal disc protrusion. The diagnoses have included unspecified disorder bursa tendons shoulder, cervicgia, and sprain/strain thoracic region. There was no evidence of a pain scaled for medication effectiveness submitted for review. Treatment to date has included medication and physical therapy. The provider requested Cyclobenzaprine 10mg, Zolpidem Tartrate ER 12.5mg, Hydrocodone-Acetaminophen 10/325 mg, Meloxicam 15mg, and Lidoderm 5%.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine 10 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41-42.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Cyclobenzaprine (Flexeril®), and on Other Medical Treatment Guideline or Medical Evidence: UpToDate, Flexeril.

**Decision rationale:** MTUS Chronic Pain Medical Treatment states for Cyclobenzaprine, "Recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. "The medical documents indicate that patient is far in excess of the initial treatment window and period. Additionally, MTUS outlines that "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. (Mens, 2005)" Uptodate "flexeril" also recommends "Do not use longer than 2-3 weeks". Medical documents do not fully detail the components outlined in the guidelines above and do not establish the need for long term/chronic usage of cyclobenzaprine. ODG states regarding cyclobenzaprine, "Recommended as an option, using a short course of therapy. The addition of cyclobenzaprine to other agents is not recommended. " Several other pain medications are being requested, along with cyclobenzaprine, which ODG recommends against. As such, the request is not medically necessary.

**Zolpidem tart ER 12. 5 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 Chapter, Ambien Section.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Zolpidem, insomnia treatment.

**Decision rationale:** The CA MTUS is silent regarding this topic. ODG states that zolpidem is a prescription short acting non-benzodiazepine hypnotic, which is approved for short-term treatment of insomnia. In this case, the patient has been taking this medication for an unknown length of time. There has been no discussion of the patient's sleep hygiene or the need for variance from the guidelines, such as a) Wake at the same time every day; (b) Maintain a consistent bedtime; (c) Exercise regularly (not within 2 to 4 hours of bedtime); (d) Perform relaxing activities before bedtime; (e) Keep your bedroom quiet and cool; (f) Do not watch the clock; (g) Avoid caffeine and nicotine for at least six hours before bed; (h) Only drink in moderation; & (i) Avoid napping. Medical documents also do not include results of these first line treatments, if they were used in treatment of the patient's insomnia. ODG additionally states "The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning. " Medical documents provided do not detail these components. As such, the request for Ambien is not medically

necessary at this time.

**Hydrodocone-Acetaminophen 10/325 mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75, 78-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute and Chronic), Low Back - Lumbar & Thoracic (Acute & Chronic), Shoulder, Pain, Opioids.

**Decision rationale:** ODG does not recommend the use of opioids for neck, low back, and shoulder pain "except for short use for severe cases, not to exceed 2 weeks. " The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that "ongoing 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 treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life.

Additionally, medical documents indicate that the patient has been on Norco in excess of the recommended 2-week limit. As such, the request for Norco is not medically necessary.

**Meloxicam 15 mg #30: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Meloxicam; NSAIDs Page(s): 61-68.

**Decision rationale:** MTUS states "Meloxicam is a non-steroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis, see NSAIDs. " MTUS guidelines for NSAIDs are divided into four usage categories: Osteoarthritis (including knee and hip), Back Pain- Acute exacerbations of chronic pain, Back Pain - Chronic low back pain, and Neuropathic pain. Regarding "Osteoarthritis (including knee and hip)", medical records do not indicate that the patient is being treated for osteoarthritis, which is the main indication for meloxicam. Regarding "Back Pain- Acute exacerbations of chronic pain", MTUS recommends as a second-line treatment after acetaminophen. Medical records do not indicate that the patients has "failed" a trial if Tylenol alone. Regarding "Back Pain - Chronic low back pain", MTUS states, "Recommended as an option for short-term symptomatic relief". The medical records indicate that the patient has been prescribed meloxicam since at least 2012, which would be considered longer than "short-term. " Regarding "Neuropathic pain," MTUS writes "There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain". Medical records do not indicate that the patient is being treated for osteoarthritis. As such, the request is not medically

necessary at this time.

**Lidoderm 5% patch #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm patches Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Topical analgesics, and on Other Medical Treatment Guideline or Medical Evidence: UpToDate. com, Lidocaine (topical).

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state "Lidoderm is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. For more information and references, see Topical analgesics. " ODG further details, "Criteria for use of Lidoderm patches :(a) Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. (b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti- depressants or an AED such as gabapentin or Lyrica). (c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. (d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale. (e) The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day). (f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks). (g) It is generally recommended that no other medication changes be made during the trial period. (h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued . (i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued. "Medical documents provided do not indicate that the use would be for post-herpetic neuralgia. Additionally, treatment notes did not detail other first-line therapy used and what the clinical outcomes resulted. As such, the request for Lidoderm 5% patches is not medically necessary.