

<b>Case Number:</b>	CM14-0133750		
<b>Date Assigned:</b>	08/25/2014	<b>Date of Injury:</b>	09/23/1998
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	07/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2014

### 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. The expert reviewer is Board Certified in Emergency Medicine and is licensed to practice in New York. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 65-year-old male who was injured on September 23, 1998. The patient continued to experience pain in his left knee and low back. Physical examination was notable for tenderness in the lower lumbar vertebrae, normal strength in the lower extremities, and tenderness along the joint lines of the left knee. Diagnoses included bilateral knee arthritis, lumbar spinal stenosis, and lumbar degenerative disc disease. Treatment included medications, hyaluronic acid injections, and aquatic physical therapy. Requests for authorization for Norco 5/325 mg #30 with 2 refills, Ambien 10 mg #30 with 2 refills, Celebrex 200 mg # 30 with 2 refills, and Lidoderm patches # 30 with 2 refills were submitted for consideration.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 5/325 MG #30 with 2 Refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 74-96.

**Decision rationale:** Norco is the compounded medication containing Hydrocodone and Acetaminophen. Chronic Pain Medical Treatment Guidelines state that opioids are not

recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain of function. It is recommended for short term use if first-line options, such as Acetaminophen or NSAIDS have failed. Opioids may be a safer choice for patients with cardiac and renal disease than antidepressants or anticonvulsants. Acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. Renal insufficiency occurs in 1 to 2% of patients with overdose. The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day. In this case the patient had been taking Hydrocodone since at least September 2013 and had not obtained analgesia. In addition, there is no documentation that the patient has signed an opioid contract or is participating in urine drug testing. Criteria for long-term opioid use have not been met. Therefore, this request is not medically necessary.

**Ambien 10 MG #30 with 2 Refills:** 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 (Acute and Chronic) chapter and Mosby's Drug Consult.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Zolpidem.

**Decision rationale:** Ambien is Zolpidem, a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. Cognitive behavioral therapy (CBT) should be an important part of an insomnia treatment plan. A study of patients with persistent insomnia found that the addition of Zolpidem immediate release to CBT was modestly beneficial during acute (first 6 weeks) therapy, but better long-term outcomes were achieved when Zolpidem IR was discontinued and maintenance CBT continued. Zolpidem has been linked to a sharp increase in ED visits, so it should be used safely for only a short period of time. In this case the patient had been taking Ambien since at least September 2013. The duration of treatment surpasses the recommended short-term duration of two to six weeks and increases the risk of adverse events. Therefore, this request is not medically necessary.

**Celebrex 200 MG #30 with 2 Refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 67-70.

**Decision rationale:** Celebrex is the selective COX-2 non-steroidal anti-inflammatory drug Celecoxib. It has been useful in the treatment of osteoarthritis, ankylosing spondylitis, and rheumatoid arthritis. Chronic Medical Treatment Guidelines state that "anti-inflammatory drugs are the traditional first line of treatment, but long term use may not be warranted". For osteoarthritis it was recommended that the lowest dose for the shortest length of time be used. It was not shown to be more effective than acetaminophen, and had more adverse side effects. Adverse effects for hypertension and renal function have been reported with COX-2 NSAIDs. Record of pain and function with the medication should be documented. The records indicate that the patient had been prescribed Celebrex prior to September 2013 and was not achieving relief. Long-term use increases the risk of side effects with no documented benefit. Therefore, this request is not medically necessary.

**Lidoderm Patches #30 with 2 Refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Lidoderm® (lidocaine patch).

**Decision rationale:** Lidocaine is recommended for localized peripheral pain after the evidence of a trial for first-line therapy, such as an antidepressant or antiepileptic drug. It is only FDA approved for the treatment of post-herpetic neuralgia. The guidelines state that further research is needed to recommend this treatment for chronic neuropathic pain. Per Official Disability Guidelines, the criteria for use of Lidoderm patches are as follows: 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. In this case the documentation does not support the pain of neuropathic etiology. In addition there has been no documentation of improvement in the pain. Criteria for the use of Lidoderm patches have not been met. Therefore, the request is not medically necessary.