

<b>Case Number:</b>	CM14-0136285		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	05/12/2006
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	08/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2014

### 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 Occupational Medicine and is licensed to practice in California. 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:

Injured worker is a male with date of injury 5/12/2006. Per pain medicine primary treating physician's progress report dated 6/5/2014, the injured worker complains of bilateral leg pain, bilateral arm pain, occipital pain greater at left, low back pain greater at left, left anterolateral thigh pain, bilateral lower back pain, and bilateral neck pain. There is persistent and increasing tingling at right side of face. On exam of the cervical spine there is tenderness of the paracervicals with increased muscle tone and the trapezius with hypertonicity. There is trapezius trigger point pain. Active range of motion is painful with restricted motion. Worst pain is with axial loading to the right while in extension. There is decreased sensation on the right in C7 distribution of the middle finger and C8 distribution of the 4th and 5th digits, ulnar hand, and distal forearm. There is decreased sensation on the left in C7 distribution of the middle finger and C8 distribution of the 4th and 5th digits, ulnar hand and distal forearm. He has an antalgic gait. Lumbar spine has tenderness of the transverse process on the right at L4 and the transverse process on the left at L4. There is tenderness of the paraspinal region at L4. Active range of motion is restricted and painful. Diagnoses include 1) cervicgia 2) cervical post-laminectomy syndrome 3) disorder of back 4) lumbar spondylosis with myelopathy 5) chronic post-traumatic headache 6) low back pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Urine drug screen:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opiates, steps to avoid misuse/addiction.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing section, Opioids Criteria for Use Page(s): 43, 112.

**Decision rationale:** The use of urine drug screening is recommended by the MTUS Guidelines, in particular when patients are being prescribed opioid pain medications and there are concerns of abuse, addiction, or poor pain control. The claims administrator referred to alternative guidelines to determine how frequent urine drug screening should be conducted. The request for 1 urine drug screen is determined to be medically necessary.

**Ambien 12.5mg #30:** Upheld

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

**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 section

**Decision rationale:** The MTUS Guidelines do not address the use of zolpidem. Per the Official Disability Guidelines, pharmacological agents should only be used for insomnia management after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically whereas secondary insomnia may be treated with pharmacological and/or psychological measures. Zolpidem reduces sleep latency and is indicated for the short-term treatment (7-10 days) of insomnia with difficulty of sleep onset and/or sleep maintenance. Adults who use zolpidem have a greater than 3-fold increased risk for early death. Due to adverse effects, FDA now requires lower doses for zolpidem. The medical records do not address the timeline of the insomnia or evaluation for the causes of the insomnia. The medical records do not indicate that non-pharmacological modalities such as cognitive behavioral therapy or addressing sleep hygiene practices prior to utilizing a pharmacological sleep aid. The request for is Ambien 12.5mg #30 determined to not be medically necessary.

**Skelaxin 800mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Metaxalone (Skelaxin) Page(s): 61.

**Decision rationale:** The MTUS Guidelines recommend the use of metaxalone with caution as a second-line option for short-term pain relief in patients with chronic low back pain. Metaxalone is a muscle relaxant that is reported to be relatively non-sedating. The claims administrator

reports that the injured worker has been treated with metaxalone since at least 7/24/2012. Chronic use of metaxalone is not consistent with the recommendations of the MTUS Guidelines, and the medical documentation does not indicate that this medication is providing benefit. Medical necessity beyond short-term use has not been established. The request for Skelaxin 800mg #90 is determined to not be medically necessary.

**Lyrica 200mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs) Page(s): 16-20.

**Decision rationale:** The MTUS Guidelines support the use of Lyrica for the treatment of diabetic neuropathy and postherpetic neuralgia. Antiepileptic drugs are recommended for the treatment of neuropathic pain. It is not clear that the injured worker is suffering from neuropathic pain, despite having some radiculopathy and sensory deficits. There is not sufficient reasoning provided by the requesting provider on why Lyrica should be considered necessary. The injured worker has been on this medication for substantial time without documentation of the benefit received from it. The guidelines define a good response as a 50% reduction in pain and a moderate response as a 30% reduction. Anti-epilepsy drugs are also recommended if they are successful in reducing the use of opioid pain medications, which has not been documented. Lyrica should not be discontinued abruptly, and weaning should occur over a one-week period. This request is not for a weaning dose however. It is also noted that Lyrica had previously been partially certified to allow for weaning. The request for Lyrica 200mg #90 is determined to not be medically necessary.

**Hydrocodone/APAP 10/325mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section, Weaning of Medications section Page(s): 74-95, 124.

**Decision rationale:** The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. It is noted that this

medication had previously been partially certified to allow for weaning. The request for Hydrocodone/APAP 10/325mg #120 is determined to not be medically necessary.