

<b>Case Number:</b>	CM14-0184715		
<b>Date Assigned:</b>	11/12/2014	<b>Date of Injury:</b>	09/07/1996
<b>Decision Date:</b>	12/19/2014	<b>UR Denial Date:</b>	11/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2014

### 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 Iowa. 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 66 year-old male with a date of injury of 9/7/1996. A review of the medical documentation indicates that the patient is undergoing treatment for rib and groin pain. Subjective complaints (10/9/2014) include chronic constant pain that is aching, sharp, stabbing, and throbbing and 5/10 in intensity, worsened by activity. Objective findings (10/9/2014) indicated hyperesthesia and hypertrophy of soft tissue over a rib scar; otherwise were not available in detail, as medical documentation did not include information other than "no changes". Diagnoses include other disorders of bone and cartilage, chronic pain (trauma), abdominal pain, and thoracic spine pain. No prior imaging studies were available for review. The patient has previously undergone multiple surgeries, although details were not available for review. A utilization review dated 11/6/2014 modified the request for Ambien 10 mg #60 to #20 (weaning), Norco 10/325 mg #90 to #45 (weaning), Opana ER 30 mg #60 to #30 (weaning), Tramadol 50 mg #120 to 45 (weaning), and did not certify the request for Lidoderm 5% patch #60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10mg 1-2 tablets every hour of sleep as needed, quantity: 60, day supply: 30:**  
Upheld

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

**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, Zolpidem, insomnia treatment

**Decision rationale:** Ambien (Zolpidem) is a short acting, non-benzodiazepine hypnotic, which is approved for short-term treatment of insomnia. MTUS does not provide recommendations on use of this medication. ODG recommends teaching and practicing proper sleep hygiene prior to initiation of medication and diagnosis of the specific component of insomnia to be addressed. Sleep hygiene recommendations include: 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. Specific components of insomnia include: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning. The treating physician has documented any discussion of sleep hygiene, diagnosis of the sleep component at issue, response to prior first-line therapies, or the need for sleep medication. The only mention of sleep in the medical documentation is that the patient is having difficulty staying asleep due to pain. The patient appears to have been taking this medication for an extended period of time, and there has been no documented discussion of the patient's sleep hygiene or additional information to justify use of the medication. There is minimal documentation relating to the current need to continue this therapy. Therefore the request for Ambien 10mg 1-2 tablets every hour of sleep as needed, quantity: 60, day supply: 30, is not medically necessary at this time.

**Norco 10mg/325mg, 1 tablet every 6 hours as needed, Quantity: 90, day supply 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 Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids

**Decision rationale:** Norco is an opioid class combination pain medication, generic name hydrocodone/acetaminophen. According to MTUS guidelines, opioids are indicated mainly for osteoarthritis only after first-line conservative options have failed, and should include clear improvement in pain and functional status for continued use. There is limited evidence to support long-term use for back or other musculoskeletal pain. MTUS also states that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur and an improved response to treatment should be observed. MTUS recommends discontinuing therapy if there is no improvement in pain or function. ODG does not recommend the use of opioids for low back pain except for short use for severe cases, not to exceed two weeks. The medical documentation indicates the patient has been on this medication for an extended period of time, exceeding the two-week recommendation for treatment length. The treating physician does mention that pain and activity has improved on the current medication regimen, but has not provided additional rationale for the extended use of this medication past

the recommended period or the need for multiple opioid medications. There is no evidence of osteoarthritis or failed conservative therapy. The documentation regarding the reported pain over time or specific improvement while on this medication is minimal, and the patient does continue to have pain and decreased functional status. Therefore, the request for Norco 10mg/325mg, 1 tablet every 6 hours as needed, Quantity: 90, day supply 30, is not medically necessary at this time.

**Opana ER 30 mg, extended release, 1 tablet every 12 hours, Quantity: 60, day supply 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 Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids

**Decision rationale:** Opana ER is the brand name for hydromorphone hydrochloride, an extended release opioid class pain medication. According to MTUS guidelines, opioids are indicated mainly for osteoarthritis only after first-line conservative options have failed, and should include clear improvement in pain and functional status for continued use. There is limited evidence to support long-term use for back or other musculoskeletal pain. MTUS also states that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur and an improved response to treatment should be observed. MTUS recommends discontinuing therapy if there is no improvement in pain or function. ODG does not recommend the use of opioids for low back pain except for short use for severe cases, not to exceed two weeks. The medical documentation indicates the patient has been on this medication for an extended period of time, exceeding the two-week recommendation for treatment length. The treating physician does mention that pain and activity has improved on the current medication regimen, but has not provided additional rationale for the extended use of this medication past the recommended period or the need for multiple opioid medications. There is no evidence of osteoarthritis or failed conservative therapy. The documentation regarding the reported pain over time or specific improvement while on this medication is minimal, and the patient does continue to have pain and decreased functional status. Therefore, the request for Opana ER 30 mg, extended release, 1 tablet every 12 hours, Quantity: 60, day supply 30, is not medically necessary at this time.

**Tramadol 50mg, 1 tablet every 6 hours, Quantity: 120, day supply 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 Opioids, Tramadol Page(s): 74-96, 113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids

**Decision rationale:** Ultram is the brand name of tramadol, and is classified as central acting synthetic opioid, exhibiting opioid activity. Therefore, similar guidelines to opioids should be followed. According to MTUS guidelines, opioids are indicated mainly for osteoarthritis only after first-line conservative options have failed, and should include clear improvement in pain and functional status for continued use. There is limited evidence to support long-term use for back or other musculoskeletal pain. MTUS also states that ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur and an improved response to treatment should be observed. MTUS recommends discontinuing therapy if there is no improvement in pain or function. ODG does not recommend the use of opioids for musculoskeletal pain except for short use for severe cases, not to exceed two weeks. According to MTUS guidelines, tramadol is not recommended as a first-line oral analgesic. ODG states that tramadol is not recommended as a first-line oral analgesic because of its inferior efficacy to a combination of Hydrocodone/ acetaminophen. The medical documentation indicates the patient has been on this medication for an extended period of time, exceeding the two-week recommendation for treatment length. The treating physician does mention that pain and activity has improved on the current medication regimen, but has not provided additional rationale for the extended use of this medication past the recommended period or the need for multiple opioid medications. Medical documentation regarding the reported pain over time or specific improvement while on this medication is minimal, and the patient does continue to have pain and decreased functional status. There is no indication why this medication is used over other options. Therefore, the request for Norco 10mg/325mg, 1 tablet every 6 hours as needed, Quantity: 90, day supply 30, is not medically necessary at this time.

**Lidoderm 5% (700mg/patch), 2 adhesive patches every 12 hours as needed, Quantity: 60, day supply: 30 with 3 refills for symptoms related to abdominal and thoracic spine injury: 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 Topical Analgesics, Lidoderm patches Page(s): 111-113, 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Topical analgesics Other Medical Treatment Guideline or Medical Evidence: UpToDate, Lidocaine (topical)

**Decision rationale:** Topical analgesics are primarily recommended for chronic pain in specific circumstances, such as neuropathic pain, when trials of antidepressants and anticonvulsants have failed. MTUS states topical lidocaine may be recommended for localized neuropathic pain after there has been evidence of a trial of first-line therapy. This medication is not a first-line treatment for chronic pain and is only FDA approved for post-herpetic neuralgia. ODG states that evidence of localized pain should be consistent with a neuropathic etiology and evidence of a trial of first-line neuropathy medications (anti-depressants or anti-epilepsy drug) should be included. A specific area for treatment should be designated as well, and outcomes should be reported. Medical documentation is limited in describing the need and rationale for the topical medication other than the aforementioned pain. The patient is on multiple other pain medications simultaneously. It does not appear from the medical documentation that all primary and

secondary treatment options have been exhausted. There is no evidence of neuropathic pain, and no clear area has been recommended for treatment. Therefore, the request for Lidoderm 5% (700mg/patch), 2 adhesive patches every 12 hours as needed, Quantity: 60, day supply: 30 with 3 refills for symptoms related to abdominal and thoracic spine injury, is not medically necessary.