

<b>Case Number:</b>	CM14-0215271		
<b>Date Assigned:</b>	01/05/2015	<b>Date of Injury:</b>	04/08/2005
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	11/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/22/2014

### 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. 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

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 patient is a 57 year old female with an injury date of 04/08/05. Based on the 08/04/14 progress report, the patient complains of right upper extremity pain. She describes her pain as being stabbing and knife-like. The 09/15/14 report indicates that the patient has severe atrophy on the right upper extremity, hypersensitivity to light touch, and a decreased range of motion in all planes. The 10/28/14 report states that the patient continues to have cervical spine radiating to the right upper extremity pain which she rates as a 6-7/10. She has fatigue, depression, memory loss, numbness, and dizziness. The patient's diagnoses include the following: 1. Right upper extremity CRPS. The utilization review determination being challenged is dated 11/20/14. Treatment reports are provided from 05/13/14- 10/28/14. Reports are hand-written and illegible.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Nucynta 100mg #60:** 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 criteria for use of opioids, medication for chronic pain Page(s): 88-89, 76-78, 60-61.

**Decision rationale:** The patient presents with cervical spine radiating to the right upper extremity pain. The request is for REMAINING NUCYNTA 100 MG #15. The patient has been taking this medication as early as 06/24/14. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The 06/24/14 report states that the patient rates her pain as an 8/10 with medications and a 10/10 without medications. On 08/04/14, she rated her pain as a 7-8/10 with medications and a 10/10 without medications. The 10/20/14 report indicates that the patient rates her pain as a 10/10 without medications and a 7/10 with medications. She is able to perform ADLs and has improved sleep. The 10/28/14 report states that the patient rates as a 6-7/10. Although the treater documents pain scales, not all 4 A's are addressed as required by MTUS Guidelines. The treater does not provide any discussion regarding side effects/adverse behavior. In regards to ADLs, the treater states the patient is able to perform ADLs [and] has improved sleep. There is no opiate management issues discussed such as CURES report, pain contracts, etc. No outcome measures are provided either as required by MTUS Guidelines. In addition, urine drug screen to monitor the medicine compliance has not been addressed. The treating physician does not provide the minimum requirements of documentation that are outlined in the MTUS Guidelines for continued opiate use. The requested nucynta IS NOT medically necessary.

**Zanaflex 4mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex) Page(s): 66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Zanaflex (Tizanidine), medication for chronic pain, Page(s): 66, 60-61.

**Decision rationale:** The patient presents with cervical spine radiating to the right upper extremity pain. The request is for ZANAFLEX 4 MG #60. The patient has been taking this medication as early as 10/20/14. MTUS Guidelines page 66 allows for the use of Zanaflex (Tizanidine) for low back pain, myofascial pain, and fibromyalgia. MTUS page 60 requires documentation of pain assessment and functional changes when medications are used for chronic pain. The 06/24/14 report states that the patient rates her pain as an 8/10 with medications and a 10/10 without medications. On 08/04/14, she rated her pain as a 7-8/10 with medications and a 10/10 without medications. The 10/20/14 report indicates that the patient rates her pain as a 10/10 without medications and a 7/10 with medications. She is able to perform ADLs and has improved sleep. The 10/28/14 report states that the patient rates as a 6-7/10. The treater provides general statements regarding pain scales; however, he does not specifically discuss efficacy of Zanaflex on any of the reports provided. There is no discussion as to how this medication has been helpful with pain and function. Page 60 of MTUS states that when medications are used for

chronic pain, recording of pain and function needs to be provided. The requested Zanaflex IS NOT medically necessary.

**Ambien 10mg #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, Insomnia Treatment

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness And Stress Chapter, Zolpidem (Ambien).

**Decision rationale:** The patient presents with cervical spine radiating to the right upper extremity pain. The request is for REMAINING AMBIEN 10 MG #15. The patient has been taking this medication as early as 06/24/14. MTUS and ACOEM Guidelines are silent with regard to this request. However, ODG Guidelines, mental illness and stress chapter, zolpidem (Ambien) states, "Zolpidem (Ambien, generic available, Ambien CR) is indicated for short-term use of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Long-term studies have found Ambien CR to be effective for up to 24 weeks in adults." ODG Guidelines support the use of Ambien for 7 to 10 days for insomnia. The patient has been taking Ambien since 06/24/2014, which is indicated to be on a long-term basis and is not recommended by ODG Guidelines. Furthermore, there is no indication that the patient has insomnia with difficulty of sleep onset. Therefore, the requested Ambien IS NOT medically necessary.

**Clonazepam 0.5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Benzodiazepines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepine Page(s): 24.

**Decision rationale:** The patient presents with cervical spine radiating to the right upper extremity pain. The request is for CLONAZEPAM 0.5 MG #60. The patient has been taking Clonazepam as early as 06/24/14. Clonazepam is a benzodiazepine. MTUS guidelines page 24 state, do not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. In this case, review of records dating from 05/16/14 to 11/25/14 indicate that this patient has been on Clonazepam since 06/24/14. Only short-term use of this medication is recommended. Furthermore, there is no documentation of how Clonazepam has specifically decreased the patient's pain and improve her function. The request IS NOT medically necessary.