

<b>Case Number:</b>	CM15-0112404		
<b>Date Assigned:</b>	06/18/2015	<b>Date of Injury:</b>	08/18/2006
<b>Decision Date:</b>	07/24/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/10/2015

### 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 51-year-old male, with a reported date of injury of 08/18/2005. The diagnoses include intractable discogenic back and leg pain, failed low back pain syndrome, deep retained hardware in the lumbosacral spine, status post hardware removal of the lumbar spine, status post lumbar spine arthrodesis, dorsal column implant placement, anxiety/depression, and insomnia. Treatments to date have included a CT (computerized tomography) scan of the lumbar spine on 01/28/2010, lumbosacral spine hardware block and intraoperative radiological examination on 06/23/2014, permanent dorsal column implant system placement on 08/22/2010, and oral medications. The progress report dated 04/28/2015 indicates that the injured worker had low back pain with radiation into both legs, and associated with tingling, numbness, and weakness. The medications were working in the dorsal pump, now at Dilaudid 1.8. It was noted that the injured worker needed to have increased medication; however, the medication caused drowsiness, and he was unable to function. The injured worker took oral medications, which decreased his pain intensity and allowed for activities of daily living. It was noted that the injured worker had difficulty with his daily activity, and needed assistance with household chores, cooking, shopping, and grooming. The objective findings include decreased lumbar range of motion, positive straight leg raise test with L5-S1 distribution, spasm and tenderness of the lumbar paraspinal muscles, hypoesthesia of the lower extremity at L3-S1 bilaterally, decreased muscle strength test at foot dorsiflexors/everters and knee extensors, and the injured worker continued to walk with a cane. The medical records indicate that Tramadol and Trazadone were discontinued on 12/03/2014. The treating physician requested Oxycotin 40mg

#60, Flexeril 10mg #90, Ambien 10mg #30, Home Healthcare Assistant with activities of daily living four hours a day, five days a week, and referral to pain management for the lumbar spine.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Oxycontin 40mg, one tab every 12 hour, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** According to ODG and MTUS, Oxycodone (Oxycontin) is a long-acting opioid analgesic. Opioid drugs are available in various dosage forms and strengths. They are considered the most powerful class of analgesics. According to the ODG, chronic pain can have a mixed physiologic etiology of both that may be used to manage both acute and chronic pain. These medications are generally classified according to potency and duration of dosage. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, the patient has continued on oral opioids and is continuing to receive intrathecal narcotics. There is no indication that long-term use of exceedingly high-dose opiates have resulted in decreased pain levels or objective functional improvement. Actually, there is documentation that this patient reported the pain was progressively worse (5/27/2014). Medical necessity of the requested opioid analgesic has not been established. Of note, discontinuation of an Oxycodone should include a taper, to avoid withdrawal symptoms. The requested Oxycontin is not medically necessary.

**Flexeril 10mg, one three times daily, #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

**Decision rationale:** According to the reviewed literature, Cyclobenzaprine (Flexeril) is a skeletal muscle relaxant and a central nervous system (CNS) depressant. It is closely related to the tricyclic antidepressants. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. It is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. Guidelines state that this medication is not recommended to be used for longer than 2-3 weeks. Based on the currently available information, the medical

necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

**Ambien 10mg, one tab before bedtime, #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, Pain Chapter.

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

**Decision rationale:** Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia and is rarely recommended for long-term use. It can be habit-forming, may impair function and memory more than opioid analgesics, and may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. There is no documentation of duration of prior Ambien use. There is no documentation provided indicating medical necessity for Ambien. The requested medication is not medically necessary.

**Home Healthcare assistant with activities of daily living 4 hours a day, 5 days a week:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Aid Page(s): 51.

**Decision rationale:** Home health services are recommended on a short-term basis following major surgical procedures or in-patient hospitalization, to prevent hospitalization, or to provide longer-term in-home medical care and domestic care services for those whose condition is such that they would otherwise require inpatient care. Home health care is the provision of medical and other health care services to the injured or ill person in their place of residence. Home health services include both medical and non-medical services deemed to be medically necessary for patients who are confined to the home (homebound) and who require one or all of the following: (1) Skilled care by a licensed medical professional for tasks including, but not limited to, administration of intravenous drugs, dressing changes, occupational therapy, physical therapy, and speech-language pathology services; and/or (2) Personal care services for tasks and assistance with activities of daily living that do not require skills of a medical professional, such as bowel and bladder care, feeding, bathing, dressing and transfer and assistance with administration of oral medications; and/or (3) Domestic care services such as shopping, cleaning, and laundry that the individual is no longer capable of performing due to the illness or injury that may also be medically necessary in addition to skilled and/or personal care services. Domestic and personal care services do not require specialized training and do not need to be performed by

a medical professional. In this case, there is no documentation of any patient's family or support system that is not able to assist in the patient's recovery. At this time, the medical records do not establish the medical necessity for the requested home healthcare assistant. This request is not medically necessary.

**Referral to pain management for the lumbar spine:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92. Decision based on Non-MTUS Citation ACOEM chapter 7, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7, page 127.

**Decision rationale:** According to the CA MTUS/ACOEM, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, the patient has chronic pain and has failed multiple conservative and interventional therapies including medical therapy, previous surgery and continued use of an intrathecal pump. Given the ongoing issues with pain control, medical necessity for the requested pain management consultation has been established. The requested consultation is medically necessary.