MAXIMUS Federal Services

Case Number:	CM15-0122759		
Date Assigned:	07/07/2015	Date of Injury:	01/10/2010
Decision Date:	08/25/2015	UR Denial Date:	05/27/2015
Priority:	Standard	Application Received:	06/25/2015

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: 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 injured worker is a 44 year old female, who sustained an industrial injury on 1/10/2010. She reported falling down from eight foot shelving onto the concrete floor, landing on her back. Diagnoses have included cervical disc displacement without myelopathy, lumbar disc displacement without myelopathy and lumbar Radiculopathy. Treatment to date has included exercise, magnetic resonance imaging (MRI), lumbar epidural steroid injections with moderate to good pain relief, one facet joint injection with moderate pain relief and medication. According to the progress report dated 5/6/2015, the injured worker complained of low back pain. She rated her pain with medications as 1/10. She rated her pain without medications as 7/10. Quality of sleep was poor. Sensory exam revealed decreased light touch sensation over the medial foot on both sides. There was positive facet provocation and tenderness. Straight leg raise was positive bilaterally. Authorization was requested for Percocet, Zoloft, Ambien CR, Nabumetone and Robaxin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg one by mouth once a day quantity 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 88, 89, 76-78.

Decision rationale: The patient presents with lower backache rated 1/10 with and 7/10 without medications. The request is for PERCOCET 10/325MG ONE BY MOUTH ONCE A DAY QUANTITY 30. The request for authorization is not provided. MRI of the lumbar spine, 04/25/11, shows degenerative disc changes of the L-spine, most prominent at the L3-4 through L5-S1. CT of the lumbosacral spine, 02/15/11, shows broad based posterior bulging of the L4-5 & L5-S1 disc without evidence for focal herniation. Physical examination reveals positive facet provocation and tenderness. Positive straight leg raise of bilateral lower extremity. Conservative treatments including 20 sessions of psychotherapy provided her with excellent relief. She has been treated with exercises which provided her with moderate pain relief. She received three to four lumbar epidural steroid injections, which provided moderate to good pain relief. She also received one facet joint injection, which provided her moderate pain relief. Her activity level has increased. Patient's medications include Zoloft, Ambien, Nabumetone, Percocet, Robaxin and Aleve. Per progress report dated 07/22/15, the patient is permanent and stationary. 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 4As -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. Pages 80, 81 of MTUS also states "There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant Radiculopathy," and for chronic back pain, it "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." Per progress report dated 07/22/15, treater's reason for the request is "as a short-acting pain medication for this patient's pain, in hopes of pain relief and improved function." The patient has been prescribed Percocet since at least 05/01/14. MTUS requires appropriate discussion of the 4A's, however, in addressing the 4A's, treater does not discuss how Percocet significantly improves patient's activities of daily living with specific examples of ADL's. Analgesia is discussed, specifically showing significant pain reduction with use of Percocet. However, no validated instrument is used to show functional improvement. There is no documentation or discussion regarding adverse effects and aberrant drug behavior. A UDS dated 06/02/14 is provided. In this case, the treater has discussed and documented some but not all of the 4A's as required by MTUS. Therefore, the request IS NOT medically necessary.

Zoloft 10mg once a day quantity 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Selective Seratonin Reuptake Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-15.

Decision rationale: The patient presents with lower backache rated 1/10 with and 7/10 without medications. The request is for ZOLOFT 10MG ONCE A DAY QUANTITY 30. The request for authorization is not provided. MRI of the lumbar spine, 04/25/11, shows degenerative disc changes of the L-spine, most prominent at the L3-4 through L5-S1. CT of the lumbosacral spine, 02/15/11, shows broad based posterior bulging of the L4-5 & L5-S1 disc without evidence for focal herniation. Physical examination reveals positive facet provocation and tenderness. Positive straight leg raise of bilateral lower extremity. Conservative treatments including 20 sessions of psychotherapy provided her with excellent relief. She has been treated with exercises which provided her with moderate pain relief. She received three to four lumbar epidural steroid injections, which provided moderate to good pain relief. She also received one facet joint injection, which provided her moderate pain relief. Her activity level has increased. Patient's medications include Zoloft, Ambien, Nabumetone, Percocet, Robaxin and Aleve. Per progress report dated 07/22/15, the patient is permanent and stationary. MTUS guidelines page 13 to 15 on antidepressants states, recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agents unless they are ineffective, poorly tolerated, or contraindicated. Assessments of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration and psychological assessment. Per progress report dated 06/03/15, treater's reason for the request is "to address both depressed mood and neuropathic pain." Patient has been prescribed Zoloft since at least 05/01/14. MTUS guidelines support the use of antidepressants as first-line treatment for neuropathic and non-neuropathic pain. In this case, although the treater documents a pain reduction from 7/10 to 1/10 with medication, treater does not discuss or document any functional improvement in the patient as required by MTUS. Therefore, the request IS NOT medically necessary.

Ambien controlled release 12.5mg one at bedtime quantity 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, Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, Zolpidem (Ambien) Section.

Decision rationale: The patient presents with lower backache rated 1/10 with and 7/10 without medications. The request is for AMBIEN CONTROLLED RELEASE 12.5MG ONE AT BEDTIME QUANTITY 30. The request for authorization is not provided. MRI of the lumbar spine, 04/25/11, shows degenerative disc changes of the L-spine, most prominent at the L3-4 through L5-S1. CT of the lumbosacral spine, 02/15/11, shows broad based posterior bulging of the L4-5 & L5-S1 disc without evidence for focal herniation. Physical examination reveals positive facet provocation and tenderness. Positive straight leg raise of bilateral lower extremity. Conservative treatments including 20 sessions of psychotherapy provided her with excellent relief. She has been treated with exercises which provided her with moderate pain relief. She received three to four lumbar epidural steroid injections, which provided moderate to good pain

relief. She also received one facet joint injection, which provided her moderate pain relief. Her activity level has increased. Patient's medications include Zoloft, Ambien, Nabumetone, Percocet, Robaxin and Aleve. Per progress report dated 07/22/15, the patient is permanent and stationary. ODG-TWC, Pain (Chronic) Chapter, Zolpidem (Ambien) Section states: "Zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which is recommended for short-term (7-10 days) 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." (Feinberg, 2008) Per progress report dated 06/03/15, treater's reason for the request is "for insomnia." Patient has been prescribed Ambien since at least 05/01/14. However, ODG recommends Ambien for only short-term use (7-10 days), due to negative side effect profile. In this case, the request for Ambien quantity 30 does not indicate intended short-term use of this medication. Therefore, the request IS NOT medically necessary.

Robaxin 500mg twice a day quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti Spasticity Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) ANTISPASMODICS Page(s): 63-66.

Decision rationale: The patient presents with lower backache rated 1/10 with and 7/10 without medications. The request is for ROBAXIN 500MG TWICE A DAY QUANTITY 60. The request for authorization is not provided. MRI of the lumbar spine, 04/25/11, shows degenerative disc changes of the L-spine, most prominent at the L3-4 through L5-S1. CT of the lumbosacral spine, 02/15/11, shows broad based posterior bulging of the L4-5 & L5-S1 disc without evidence for focal herniation. Physical examination reveals positive facet provocation and tenderness. Positive straight leg raise of bilateral lower extremity. Conservative treatments including 20 sessions of psychotherapy provided her with excellent relief. She has been treated with exercises which provided her with moderate pain relief. She received three to four lumbar epidural steroid injections, which provided moderate to good pain relief. She also received one facet joint injection, which provided her moderate pain relief. Her activity level has increased. Patient's medications include Zoloft, Ambien, Nabumetone, Percocet, Robaxin and Aleve. Per progress report dated 07/22/15, the patient is permanent and stationary. MTUS page 63-66 Muscle relaxants (for pain) states recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP MTUS page 63-66 under ANTISPASMODICS for Methocarbamol (Robaxin, Relaxin, generic available) states: The mechanism of action is unknown, but appears to be related to central nervous system depressant effects with related sedative properties. Per progress report dated 06/03/15, treater's reason for the request is "for muscle spasms. SE's and use discussed." The patient has been prescribed Robaxin since at least 02/11/15. MTUS guidelines recommend non-sedating muscle relaxants for short-term use. However, Robaxin has sedating properties, which

does not appear to be in accordance with MTUS guidelines. Furthermore, the request for additional Roxbaxin quantity 60 does not indicate intended short-term use of this medication. Therefore, the request IS NOT medically necessary.