

<b>Case Number:</b>	CM15-0039878		
<b>Date Assigned:</b>	03/10/2015	<b>Date of Injury:</b>	07/31/2000
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	02/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2015

### 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 (IW) is a 59-year-old male who sustained an industrial injury on 07/31/2000. According to the progress notes dated 1/5/15, the IW reported pain and discomfort in the low back, bilateral lower extremities, neck and left shoulder. The pain is worst in the left leg and heel. The IW was diagnosed with bilateral lower extremities complex regional pain syndrome, cervical and lumbar degenerative disc disease, myofascial pain syndrome, bilateral ulnar neuropathy, cervical radiculitis and left hip pain. Treatment to date has included medications, trigger point injections and surgery. The IW states pain with his current medications is 4-5/10 and without them is 7-8/10. The provider's plan of care includes continuing current medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet 5/325mg, #60 with 2 refills:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

**Decision rationale:** The patient presents with unrated pain and discomfort to the lower back, bilateral lower extremities, neck, and left shoulder. The patient's date of injury is 07/31/00. Patient is status post trigger point injections at a date and location unspecified. The request is for PERCOCET 5/325MG #60 WITH TWO REFILLS. The RFA was not provided. Physical examination dated 01/05/15 reveals tenderness to palpation of the lumbar paraspinal muscles, lumbar spinous processes, bilateral levator scapulae, and bilateral trapezius muscles. Treater also notes a large scar and deformity to the left ankle and calf. The patient is currently prescribed Oxycontin, Percocet, Neurontin, Tizanidine, and Ambien. Diagnostic imaging was not included. Patient's current work status was not provided. 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. In regard to the request of Percocet for the management of this patients intractable pain, the request appears reasonable. Progress notes provided indicate that this patient has been taking Percocet since at least 02/24/14. Progress note dated 01/05/15 includes a reduction in this patient's pain level from 7-8/10 to 4/10 attributed to medications. It also provides specific functional improvement: "without the medications he can only walk for 10 minutes with the medications he can walk up to 60-90 minutes, they allow him to care for his elderly mother." The same progress note also discusses a lack of aberrant behavior and the documentation includes a consistent urine drug screen dated 01/07/15. The provided documentation satisfies the 4A's as required by MTUS to substantiate Percocet's continued use. The request IS medically necessary.

**Ambien 6.25mg #60 with 2 refills:** 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain Chapter, Zolpidem - Ambien.

**Decision rationale:** The patient presents with unrated pain and discomfort to the lower back, bilateral lower extremities, neck, and left shoulder. The patient's date of injury is 07/31/00. Patient is status post trigger point injections at a date and location unspecified. The request is for AMBIEN 6.25MG #60 WITH 2 REFILLS. The RFA was not provided. Physical examination dated 01/05/15 reveals tenderness to palpation of the lumbar paraspinal muscles, lumbar spinous processes, bilateral levator scapulae, and bilateral trapezius muscles. Treater also notes a large scar and deformity to the left ankle and calf. The patient is currently prescribed Oxycontin, Percocet, Neurontin, Tizanidine, and Ambien. Diagnostic imaging was not included. Patient's current work status was not provided. ODG-TWC, Pain Chapter, Zolpidem -Ambien- Section states: "Zolpidem is a prescription short-acting nonbenzodiazepine 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." In regard to the request for Ambien, treater has exceeded the recommended duration of therapy. This patient has been taking Ambien since at least 02/24/15, though there is no documentation of efficacy in the subsequent reports. This patient's CRPS of the left lower extremity likely causes significant sleep disturbance, however this medication is not intended for long-duration use. The requested 60 tablets with 2 refills does not imply limited use and there is no documentation of prior efficacy, either. Therefore, the request IS NOT medically necessary.

**Neurontin 300mg #270 with 2 refills: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy drug.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 18-19.

**Decision rationale:** The patient presents with unrated pain and discomfort to the lower back, bilateral lower extremities, neck, and left shoulder. The patient's date of injury is 07/31/00. Patient is status post trigger point injections at a date and location unspecified. The request is for NEURONTIN 300MG #270 WITH 2 REFILLS. The RFA was not provided. Physical examination dated 01/05/15 reveals tenderness to palpation of the lumbar paraspinal muscles, lumbar spinous processes, bilateral levator scapulae, and bilateral trapezius muscles. Treater also notes a large scar and deformity to the left ankle and calf. The patient is currently prescribed Oxycontin, Percocet, Neurontin, Tizanidine, and Ambien. Diagnostic imaging was not included. Patient's current work status was not provided. MTUS has the following regarding Gabapentin on pg 18, 19: "Gabapentin -Neurontin, Gabarone, generic available- has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." In this case, a prescription for Gabapentin was initiated sometime before 02/24/14 progress note, as it specifies a refill. The patient suffers from CRPS of the left lower extremity, for which Gabapentin is indicated. Progress note dated 01/05/15 discusses a reduction in pain attributed to this patient's medications and that this medication helps relieve the localized burning in the left lower extremity. Given documentation of pain reduction and specific symptomatic relief attributed to this medication, continuation is substantiated. The request IS medically necessary.

**Zanaflex 2mg, #240 with 2 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Medications for chronic pain Page(s): 66, 60.

**Decision rationale:** The patient presents with unrated pain and discomfort to the lower back, bilateral lower extremities, neck, and left shoulder. The patient's date of injury is 07/31/00. Patient is status post trigger point injections at a date and location unspecified. The request is for ZANAFLEX 2MG #240 WITH 2 REFILLS. The RFA was not provided. Physical examination dated 01/05/15 reveals tenderness to palpation of the lumbar paraspinal muscles, lumbar spinous processes, bilateral levator scapulae, and bilateral trapezius muscles. Treater also notes a large scar and deformity to the left ankle and calf. The patient is currently prescribed Oxycontin, Percocet, Neurontin, Tizanidine, and Ambien. Diagnostic imaging was not included. Patient's current work status was not provided. MTUS Chronic Pain Medical Treatment Guidelines for Muscle Relaxants for pain, pg 66 states the following regarding Tizanidine: "Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. One study, conducted only in females, demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain." MTUS p60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain." In regard to the request for Zanaflex, this patient has been taking this medication since at least 02/24/15. The subsequent progress notes do not specifically discuss this medication's efficacy. Progress notes do not provide any evidence that this patient possesses muscle spasms during physical examination or provide subjective reports of spasms, either. While this patient presents with a significant clinical history, he does not appear to suffer from muscle spasms for which this medication is indicated. Owing to a lack of documented efficacy of this medication or symptoms for which it is indicated, continuation cannot be substantiated. The request IS NOT medically necessary.