

<b>Case Number:</b>	CM15-0047854		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	09/29/2005
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	03/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2015

### 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 52-year-old female, with a reported date of injury of 09/29/2005. The diagnoses include back pain, cervical syndrome with radiculopathy, thoracic musculo-ligamentous sprain, lumbosacral syndrome with sciatica, cervical radiculopathy, lumbar radiculopathy, and lumbar disc and root pain. Treatments to date have included oral medications, an MRI of the lumbar spine, and an MRI of the cervical spine. The progress report dated 02/23/2015 is handwritten and somewhat illegible. The report indicated that the injured worker had back pain. The objective findings include limited back range of motion. The treating physician requested Opana 10mg #180, Flector patch #90, and Ambien 12.5mg #60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Opana 10mg, #180:** Upheld

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

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

**Decision rationale:** Based on the 02/23/15 progress report provided by treating physician, the patient presents with back pain. The request is for OPANA 10MG, #180. Patient's diagnosis per Request for Authorization form dated 02/24/14 includes lumbar disc root pain. Physical examination to the lumbar spine on 02/23/15 revealed limited range of motion. Treatment to date included imaging studies and medications. Patient medications include Opana, and Ambien. The patient is temporarily totally disabled, per 02/23/15 treater report. Regarding chronic opiate use, MTUS guidelines page 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. MTUS p 77 states, "Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." Opana has been included in patient's medications, per treater reports dated 07/10/14, 12/01/14, and 02/23/15. In this case, treater has not stated how Opana reduces pain and significantly improves patient's activities of daily living. There are no pain scales or validated instruments addressing analgesia. MTUS states that "function should include social, physical, psychological, daily and work activities." There are no specific discussions regarding aberrant behavior, adverse reactions, ADLs, etc. No UDS's, opioid pain agreement or CURES reports. No return to work, or change in work status, either. MTUS requires appropriate discussion of the 4As. Given the lack of documentation as required by guidelines, the request IS NOT medically necessary.

**Flector Patch #90:** 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 (Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesic Page(s): 111-113.

**Decision rationale:** Based on the 02/23/15 progress report provided by treating physician, the patient presents with back pain. The request is for FLECTOR PATCH #90. Patient's diagnosis per Request for Authorization form dated 02/24/14 includes lumbar disc root pain. Physical examination to the lumbar spine on 02/23/15 revealed limited range of motion. Treatment to date included imaging studies and medications. Patient medications include Opana, and Ambien. The patient is temporarily totally disabled, per 02/23/15 treater report. Flector patch is Diclofenac in a topical patch. Regarding topical NSAIDs, MTUS topical analgesics pages 111-113 states, "Indications: Osteoarthritis and tendonitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." It appears Flector patch is being initiated on 02/23/14, per RFA. Treater has not provided reason for the request, nor indicated what body part would be treated. Nonetheless, the patient

does not present with peripheral joint arthritis/tendinitis, for which a topical NSAID would be indicated. Flector patch is not indicated for back pain. This request is not in accordance with MTUS indications. Therefore, the request IS NOT medically necessary.

**Ambien 12.5mg, #60:** 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 Pain (Chronic) Chapter, Zolpidem (Ambien).

**Decision rationale:** Based on the 02/23/15 progress report provided by treating physician, the patient presents with back pain. The request is for AMBIEN 12.5MG, #60. Patient's diagnosis per Request for Authorization form dated 02/24/14 includes lumbar disc root pain. Physical examination to the lumbar spine on 02/23/15 revealed limited range of motion. Treatment to date included imaging studies and medications. Patient medications include Opana, and Ambien. The patient is temporarily totally disabled, per 02/23/15 treater report. ACOEM and MTUS Guidelines do not address Ambien. ODG-TWC, Pain (Chronic) 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. (Feinberg, 2008)" Ambien has been included in patient's medications, per treater reports dated 12/01/14 and 02/23/15. Ambien has been prescribed at least since 12/01/14, which is 3 months from UR date of 03/04/15. In this case, ODG recommends Ambien for short-term (7-10 days) treatment of insomnia. Furthermore, the request for quantity 60 exceeds guideline recommendation, and does not indicate intended short-term use of this medication. The request is not accordance with guidelines. Therefore, the request IS NOT medically necessary.