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| <b>Case Number:</b>   | CM13-0003009 |                              |            |
| <b>Date Assigned:</b> | 12/11/2013   | <b>Date of Injury:</b>       | 02/27/2003 |
| <b>Decision Date:</b> | 01/16/2014   | <b>UR Denial Date:</b>       | 07/16/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/24/2013 |

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in physical medicine and rehabilitation and is licensed to practice in California. 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 physician 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/services.

### 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 62-year-old who reported an injury on 02/27/2003. The patient is currently diagnosed with shoulder pain, status post arthroscopy times 2. The patient was recently seen by [REDACTED] on 11/18/2013. The patient reported worsening pain with severe psoriasis and open ulcers in bilateral lower extremities. The patient also reported poor sleep quality and decreased activity level. Physical examination revealed antalgic gait, restricted cervical range of motion, paravertebral muscle spasm with tenderness and tight muscle banding, tenderness of the paracervical muscles, rhomboids and trapezius, restricted right shoulder range of motion, positive Hawkins and Neer testing, tenderness over the acromioclavicular joint, biceps groove and subdeltoid bursa, diminished strength with shoulder external rotation, and intact sensation. Treatment recommendations included continuation of current medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10mg #20:** 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 Chronic Pain Chapter, Insomnia Treatment

**Decision rationale:** The Physician Reviewer's decision rationale: The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for

the short-term treatment of insomnia with difficulty of sleep onset for only 7 to 10 days. Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite the ongoing use, the patient continues to report difficulty falling asleep and staying asleep.

**Lyrica 50mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19, 99.

**Decision rationale:** The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines state Lyrica has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, and has FDA approval for both indications. As per the clinical notes submitted, the patient has continuously utilized this medication. The latest office visit note dated 11/18/2013, indicated that the patient reported worsening pain, a decrease in activity level, and poor sleep quality. Previous office visits with [REDACTED] from 03/04/2013 through 10/21/2013, indicated that the patient's pain level remained unchanged. The patient continued to report upper back and right shoulder pain despite the ongoing use of this medication. Satisfactory response to treatment has not been indicated. The request for Lyrica 50mg, 90 count, is not medically necessary or appropriate.

**Prozac 10mg #60:** 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:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 107.

**Decision rationale:** The Physician Reviewer's decision rationale: The Chronic Pain Medical Treatment Guidelines state SSRIs (selective serotonin reuptake inhibitors) are not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. As per the clinical notes submitted, there is no indication that this patient suffers from a major depressive disorder. The patient has continuously utilized this medication within the past year. Despite the ongoing use, the patient's subjective complaints and physical examination remain unchanged. Satisfactory response to treatment has not been indicated. Medical necessity for the requested medication has not been established. The request for Prozac 10mg, 60 count, is not medically necessary or appropriate.