

<b>Case Number:</b>	CM13-0005965		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	09/08/2010
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	07/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/01/2013

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 50-year-old female who reported an injury on 04/22/2004 of an unknown mechanism. She complained of pain to the right side and back of the neck, shoulders, low back, both hands and right knee. She rated her pain at 3/10 and an average of 3-8/10 on a 0 to 10 scale. The physical findings on 03/13/2013 were a mildly antalgic gait with decreased stance phase and push-off on the right leg compared to the left; no change in gait with the use of a single point cane. An upper body evaluation was not done since there were no changes in her upper body symptoms or functional limitations. Lumbar range of motion was done after warm ups using dual inclinometer method and the values were flexion: 20/20/20 degrees, extension: 10/10/10 degrees, lateral bending 10/10/10 degrees bilaterally. She complained of pain with all movements, with worse pain going from flexed to upright position with lumbar extension. A sacroiliac (SI) belt made her feel more supported with ambulation; pain behaviors were observed during lumbar range of motion. The straight leg raise on the left was 40 degrees; she could not do a straight leg raise on the test on the right given her tolerance for the activity. The hip range of motion or Faber's was not done due to pain behaviors. There was tenderness over the lumbar paraspinal and SI (sacroiliac) joint regions bilaterally. There was no sciatic notch or trochanteric tenderness. The range of motion of the knee was noted as follows: right/left flexion: 115/130 degrees, extension: 0/0 degrees, tenderness over the right medial joint line, supra, and medial aspect of the patella. The patella compression test was positive on the right; Lachman's and McMurray's were negative bilaterally. There was no ligament laxity noted and the left knee examination was completely normal. Range of motion of the ankle was normal without pain bilaterally. The lower extremity muscle strength testing was normal with the exception of right ankle dorsiflexion of 4/5. She had difficulty during heel raising bilaterally with difficulty on the right more so than the left. The lower extremity reflexes were present at the knees and absent at both ankles. The lower

extremity sensation was decreased to pinprick in the right L5 dermatomal distribution. There were no diagnostics for review; however, documentation noted X-rays of the bilateral knees and an MRI of a knee had been done. The past treatments included aquatic therapy, pain management counseling, and an ergonomic evaluation. Her diagnoses were chronic right knee pain, right knee osteoarthritis, status post right knee arthroscopic surgery, probable patellofemoral syndrome, history of torn lateral meniscus, chronic right shoulder pain with right shoulder impingement syndrome, bilateral hand pain with de Quervain's tenosynovitis, chronic neck pain with cervical myofascial pain, chronic low back pain with lumbar myofascial pain, multilevel lumbar spondylosis, right S1 radiculopathy, history of migraines, and reactive depression and anxiety. The treatment plan was to continue pain management counseling sessions for a total of 12 sessions, instruction by physical therapy on how to do patellar tapping, 8 sessions of aquatic therapy with the progression to an independent aquatic exercise program, close monitoring of Norco with laboratory tests to monitor renal and liver function, and 8 to 12 physician visits per year for medications and management of flare ups. The Request for Authorization form was not submitted for review. There was no rationale for the requests.

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

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

**Ambien 5mg #15 with 1 refill #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute, ODG Treatment of worker's Compensation, 5th Edition, Pain Chapter (Updated 06/07/2013), Zolpiden (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, zolpiden (ambien).

**Decision rationale:** The injured worker complained of pain to the right side and back of the neck, shoulders, low back, both hands and right knee. She rated her pain at 3/10 and an average of 3-8/10 on a 0 to 10 scale. Her past treatments included aquatic therapy, pain management counseling, and an ergonomic evaluation. The Official Disability Guidelines recommend Zolpidem as a short-acting, nonbenzodiazepine hypnotic which is approved for the short-term (usually 2 to 6 weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and is often hard to obtain. Various medications may provide short-term benefits. While sleeping pills, so-called minor tranquilizers, and antianxiety agents are commonly prescribed for 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. The lack of documentation provided does not support the need for the use of Ambien and does not state how long the injured worker has been on the medication. Therefore, the request for Ambien 5mg #15 with 1 refill #30 is not medically necessary and appropriate.

**Fioricet 50/325/40mg #90 with 1 refill # 180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter (Updated 06/07/13), Barbiturate-containing analgesic agents (BCAs).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain, Fioricet and barbiturate-containing analgesic agents (BCAs).

**Decision rationale:** The injured worker complained of pain to the right side and back of the neck, the shoulders, the low back, and hands and right knee. She rated her pain at 3/10 and an average of 3-8/10 on a 0 to 10 scale. Her past treatments included aquatic therapy, pain management counseling, and an ergonomic evaluation. The Official Disability Guidelines state that Fioricet is not recommended. It is a barbiturate containing analgesic (BCA) agent and the potential for dependence is high and no clinical evidence exists to show how clinically important enhancements of analgesic efficacy of BCAs due to the barbiturate constituents. Fioricet is commonly used for acute headaches, with some data to support it, but there is a risk of medication overuse as well as rebound headaches. Given the above, the request for Fioricet 50/325/40 mg #90 with 1 refill, quantity of 180, is not medically necessary and appropriate.

**Lidoderm 5% patch #60 with 1 refill #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch) Page(s): 56-57.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57.

**Decision rationale:** The injured worker complained of pain to the right side and back of the neck, the shoulders, the low back, both hands and right knee. She rated her pain at 3/10 and an average of 3- 8/10 on a 0 to 10 scale. The past treatments included aquatic therapy, pain management counseling, and an ergonomic evaluation. The California MTUS Guidelines state that topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy, such as tricyclic or (SNRI) Serotonin-Norepinephrine Reuptake Inhibitor antidepressants or (AEDs) Antiepileptic Drugs such as gabapentin or Lyrica, it is not recommended as a first line therapy and is only FDA approved for post herpetic neuralgia. Research is needed to recommend this treatment for chronic neuropathic pain disorders other than post herpetic neuralgia. The documentation provided does not support the use of Lidoderm 5% patch or evidence of a trial of first line therapy, such as tricyclic or SNRI antidepressants or AEDs such as gabapentin or Lyrica. Therefore, the request for Lidoderm 5% patch #60 with 1 refill #120 is not medically necessary and appropriate.

**Thermacare Heat wrap #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

**Decision rationale:** The injured worker complained of pain to the right side and back of the neck, shoulders, low back, both hands and right knee. She rated her pain at 3/10 and an average of 3-8/10 on a 0 to 10 scale. Her past treatments included aquatic therapy, pain management counseling, and an ergonomic evaluation. The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. It also states that any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. CA MTUS/ACOEM and ODG guidelines do not support the use of this type of heat wrap. Given the above, the request for Thermacare Heat wrap #30 is not medically necessary and appropriate.