

<b>Case Number:</b>	CM13-0027224		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	09/01/2005
<b>Decision Date:</b>	01/15/2014	<b>UR Denial Date:</b>	08/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/20/2013

### 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. 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 patient is a 46-year-old female who reported an injury on 09/01/2005. The patient is currently diagnosed with status post right total knee arthroplasty, left knee medial and collateral ligament tear with meniscus injury, lumbar myoligamentous injury with degenerative disc disease, bilateral lower extremity radiculopathy, cervical myoligamentous injury with degenerative changes, cervical dystonia, bilateral upper extremity radiculopathy, reactionary depression and anxiety, left knee ACL medial and lateral collateral ligament repair, right shoulder internal derangement, and migraine headaches. The patient was recently evaluated by [REDACTED] on 09/05/2013. The patient reported persistent pain and weakness in the right knee. The patient also complained of pain to the left knee. Physical examination revealed antalgic gait, tenderness to palpation of bilateral cervical musculature, numerous trigger points palpable and tender throughout the cervical paraspinal muscles, upper trapezius, and medial scapular regions bilaterally, decreased range of motion with guarding, weakness in bilateral upper extremities, tenderness to palpation along the joint line of the right shoulder, limited range of motion of the right shoulder, tenderness to palpation along the posterior lumbar musculature bilaterally with diffuse muscle rigidity, decreased range of motion of the lumbar spine, positive straight leg raising, decreased sensation along the right posterolateral thigh and calf at L5-S1 distribution, tenderness to palpation of bilateral knees, crepitus with gentle range of motion of bilateral knees, limited range of motion of bilateral knees, and tenderness along the medial and lateral joint line. 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:

**Prozac 20mg, #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 107.

**Decision rationale:** California MTUS Guidelines state SSRIs 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, the patient is already taking the antidepressant medication Wellbutrin. The patient does report neuropathic pain, for which tricyclic antidepressants are generally considered as first line agents unless they are ineffective, poorly tolerated, or contraindicated. There is no indication that this patient has failed a trial of first line therapy with tricyclic antidepressants. The medical necessity for the requested medication has not been established. As such, the request is non-certified.

**Norco 10/325mg, #300: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, medication use, and side effects should occur. As per the clinical notes submitted, the patient has continuously utilized this medication. Despite the ongoing use, the patient continues to report high levels of pain. There has been no evidence of functional improvement with the continued use of opioids. Satisfactory response to treatment has not been indicated. Therefore, continuation cannot be determined as medically appropriate. Therefore, the request is non-certified.

**Retrospective medication request for Imitrex 100 mg every day as needed for migraines, #9: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head Chapter, Triptans

**Decision rationale:** Official Disability Guidelines state triptans are recommended for migraine sufferers. At marketed doses, all triptans are effective and well tolerated. As per the clinical notes submitted, there is no clarification regarding the onset of headaches, duration of headaches,

alleviating factors, aggravating factors, or previous treatments that have been trialed. The patient has continuously utilized this medication. Satisfactory response to treatment has not been indicated. Therefore, continuation cannot be determined as medically appropriate. As such, the request is non-certified.

**Retrospective medication request for Ambien 10 mg 2 every night at bed time, #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

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

**Decision rationale:** Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for short-term treatment of insomnia with difficulty with sleep onset for 7 to 10 days. As per the clinical notes submitted, there is no indication that this patient has failed a trial of non-pharmacological attempts at good sleep hygiene. As guidelines do not recommend long-term use of this medication, the ongoing use cannot be determined as medically appropriate. Based on the clinical information received and the Official Disability Guidelines, the request is non-certified.

**Retrospective medication request for Fexmid 7.5 mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations in patients with chronic low back pain. However, in lower back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. Cyclobenzaprine is recommended for a short course of therapy and should not be used for longer than 2 to 3 weeks. As per the clinical notes submitted, the patient has continuously utilized this medication for greater than 2 to 3 weeks. Satisfactory response to treatment has not been indicated. As guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. As such, the request is non-certified.