

<b>Case Number:</b>	CM13-0069272		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	03/12/2001
<b>Decision Date:</b>	04/15/2014	<b>UR Denial Date:</b>	12/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/20/2013

### 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 Neuromusculoskeletal Medicine and is licensed to practice in Arizona. 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:

This is a 55-year-old female who reported feeling a tearing and popping in her right knee on 03/12/01 while handing pipe risers in a storeroom. Afterward her pain gradually worsened to encompass not only her knee but also her lumbar, cervical and opposing knee. Since then, she has been diagnosed with a right knee post-traumatic osteoarthritis, left knee medical compartmental osteoarthritis that is post-traumatic, right shoulder rotator cuff syndrome, cervical disc herniation with left upper extremity radiculopathy, lumbar stenosis and status post laminectomy with worsened pain and left lower extremity radiculopathy. The patient's primary treating physician progress report dated on 11/18/13 documents that her pain is not improving, she is experiencing bilateral upper extremity pain radiation from the cervical region and lower extremity lumbar radiculopathy with her pain refractory to cervical epidural injections. She has undergone a five injection series of Supartz to the right knee to treat her traumatic osteoarthritis. On the primary treating physician progress report dated 8/22/13, reported to see improvement in the patient's pain level from 7/10 to 4-5/10 with use of her pain medication. A lumbar MRI dated 10/08/13 documents 'right laminotomy defect L5-S1 with multilevel discogenic disease of the lumbar spine, most prominent at L4-5; L4-5 moderate central stenosis with moderate right, mild left lateral recess narrowing and mild right to mild to moderate left neuroforaminal narrowing; Post annular fissures at L3-4 and L5-S1.'

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anexsia 7.5/325 #30:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 91.

**Decision rationale:** Hydrocodone/Acetaminophen (Anexsia<sup>®</sup>, Co-Gesic<sup>®</sup>, Hycet<sup>TM</sup>; Lorcet<sup>®</sup>, Lortab<sup>®</sup>; Margesic- H<sup>®</sup>, Maxidone<sup>TM</sup>; Norco<sup>®</sup>, Stagesic<sup>®</sup>, Vicodin<sup>®</sup>, Xodol<sup>®</sup>, Zydone<sup>®</sup>; generics available): Indicated for moderate to moderately severe pain. Since the medication is indicated for moderate to moderately severe pain and the patient continues to experience moderate pain without its use, I find that it is medically necessary.

**Lidoderm patches 5% #30, apply to affected area 12 hours on and 12 hours off:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 56.

**Decision rationale:** Lidoderm<sup>®</sup> is the brand name for a lidocaine patch produced by [REDACTED]. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or serotonin-norepinephrine reuptake inhibitor (SNRI) anti-depressants or an automated external defibrillator (AED) such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. For more information and references, see Topical analgesics. After review of all provided medical documentation, I found no evidence of the use of first-line therapy agents (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Since no evidence is provided of the failure of first line treatment and that Lidoderm patches are FDA approved for the treatment of post-herpetic neuralgia, I find that its use is not medically necessary.

**Ambien 5mg #30, 2 tabs approx. 30 minutes before bedtimes:** 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 (ODG) Insomnia

**Decision rationale:** It is recommended that treatment be based on the etiology, with the medications recommended below. See Insomnia. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to

resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. (Lexi-Comp, 2008) Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning. Zolpidem [Ambien® (generic available), Ambien CR®] is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Non-pharmacologic treatment: Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. Treatments that are thought to probably be efficacious include sleep restriction, biofeedback, and multifaceted cognitive behavioral therapy. Suggestions for improved sleep hygiene: (a) Wake at the same time everyday; (b) Maintain a consistent bedtime; (c) Exercise regularly (not within 2 to 4 hours of bedtime); (d) Perform relaxing activities before bedtime; (e) Keep your bedroom quiet and cool; (f) Do not watch the clock; (g) Avoid caffeine and nicotine for at least six hours before bed; (h) Only drink in moderation; & (i) Avoid napping. There is no documentation regarding sleep hygiene on any of the progress reports provided for this review. As Ambien is FDA approved for short term (7-10 days) of treatment for insomnia, I find that the continued use of this medication is not medically necessary.