

<b>Case Number:</b>	CM14-0004374		
<b>Date Assigned:</b>	02/05/2014	<b>Date of Injury:</b>	09/11/2008
<b>Decision Date:</b>	06/23/2014	<b>UR Denial Date:</b>	12/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2014

### 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 and Rehabilitation, and is licensed to practice in Texas. 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 53-year-old female who reported an injury on 9/11/08. The mechanism of injury was not provided for review. The injured worker sustained an injury to his low back that resulted in multiple surgical interventions. The injured worker's chronic pain was managed with medications. The injured worker was evaluated on 12/4/13. It was documented that the injured worker had 9/10 low back pain that radiated into the bilateral lower extremities. Objective physical findings included an antalgic gait with assisted ambulate with a cane, absent left Achilles reflex and +1 Achilles reflex on the right with restricted range of motion of the lumbar spine and 4/5 motor strength of the extensor hallucis longus bilaterally. The injured worker's medications included Celebrex, capsaicin cream, Ketamine cream, Ambien, Senokot, Bupropion, and Tylenol. The injured worker's diagnoses included post-laminectomy syndrome and sciatica. The injured worker's treatment plan included a refill of medications, biofeedback therapy, and cognitive behavioral therapy. A request was made to refill Lidoderm patches and Ambien.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRESCRIPTION FOR AMBIEN 10MG, #30 WITH 3 REFILLS:** 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 (ODG) Pain chapter, Insomnia Treatment

**Decision rationale:** The California MTUS/ACOEM guidelines do not address this medication, so alternative guidelines were used. The Official Disability Guidelines do not support the long-term use of Ambien as a treatment for insomnia-related to chronic pain. The clinical documentation does indicate that the injured worker has been taking the medication since at least June 2012. However, the treating physician has documented that the injured worker takes this on an as needed basis and not on successive nights. It was documented that the injured worker did receive restorative sleep without adverse side effects. Therefore, a refill would have been appropriate; however, the request includes three refills. This does not allow for timely reassessment or re-evaluation to establish the continued efficacy and safety of this medication. Additionally, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined, and the request is not medically necessary.

**PRESCRIPTION FOR LIDODERM PATCH 5%, #60 WITH 3 REFILLS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines recommend that ongoing use of this medication be supported by documentation of functional benefit and pain relief. The clinical documentation submitted for review does indicate that the injured worker receives pain relief, and the requested medication allows for improved mobility. However, the request as it is submitted does not clearly identify a frequency of treatment. Therefore, the appropriateness of the request itself cannot be determined. Also, the request is for three refills. This will not allow for timely reassessment and re-evaluation of the continued efficacy of this medication. As such, the request is not medically necessary.