

<b>Case Number:</b>	CM14-0155104		
<b>Date Assigned:</b>	10/01/2014	<b>Date of Injury:</b>	05/31/2006
<b>Decision Date:</b>	11/24/2014	<b>UR Denial Date:</b>	09/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2014

### 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 Occupational Medicine 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 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:

Patient is a 62 year-old male with date of injury 05/31/2006. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 08/22/2014, lists subjective complaints as chronic bilateral low back pain. Radiation of pain extends to the right L4-5 distribution and right S1 distribution. Patient claimed for one week the lower right extremity felt cold then returned to normal. Objective findings: Examination of the lumbar spine revealed tenderness to palpation over the paraspinal muscles overlying the facet joints and SI joints on both sides of the midline. Straight leg raising seated was negative. Diagnosis: 1. Insomnia 2. Lumbar post-laminectomy syndrome 3. Mononeuritis of lower limb. The medical records supplied for review document that the patient has been taking the following medications for at least as far back as 5 months. Medications: 1. Ambien 10mg tab, #30 SIG: 1 tablet at bedtime 2. Norco 10-325 tab, #40 SIG: 2 tablets four times a day 3. Tizanidine tab 4mg, #30 SIG: 1 tablet at bedtime 4. Dilaudid 4mg, #30 SIG: 1 tablet every 4 to 6 hours 5. Lyrica 50mg capsule, #120 SIG: two capsules twice a day

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10mg tab, #30, 1 refill:** 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) Pain (Chronic), Insomnia treatment

**Decision rationale:** The Official Disability Guidelines do not recommend the long-term use of any class of sleep aid. The patient has been taking Ambien for at least 5 months. AS such, Ambien 10mg tab, #30, 1 refill is not medically necessary.

**Norco 10-325mg tab, #40, 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-96.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of narcotics, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 5 months. As such, Norco 10-325mg tab, #40, 1 refill is not medically necessary.

**Tizanidine tablet 4mg #30, 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

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

**Decision rationale:** Tizanidine is a drug that is used as a muscle relaxant. The MTUS states that muscle relaxants are recommended with caution only on a short-term basis. The patient has been taking the muscle relaxant for an extended period of time. Tizanidine tablet 4mg #30, 1 refill is not medically necessary.

**Dilaudid 4mg, #30, 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement

or improved quality of life. Despite the long-term use of narcotics, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 5 months. In addition, according to the MTUS in regard to medications for chronic pain, only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. Dilaudid 4mg, #30, 1 refill is not medically necessary.

**Lyricea 50mg capsule, #120, 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19, 20.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19-20.

**Decision rationale:** The MTUS states that Lyricea has FDA approval for painful diabetic neuropathy, postherpetic neuralgia, and fibromyalgia. The patient is not diagnosed with the above indications. In addition, a recent review has indicated that there is insufficient evidence to recommend for or against antiepileptic drugs for axial low back pain. Therefore, Lyricea 50mg capsule, #120, 1 refill is not medically necessary.