

<b>Case Number:</b>	CM14-0030636		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	05/09/2001
<b>Decision Date:</b>	07/17/2014	<b>UR Denial Date:</b>	02/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2014

### 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 & Rehabilitation, has a subspecialty in Sports Medicine 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 05/09/2009. The mechanism of injury was not specifically stated. The current diagnoses include probable lumbar facet mediated pain, lumbar degenerative disc disease, Complex Regional Pain Syndrome (CRPS) in the right lower extremity, spinal cord stimulator, and intrathecal pump. The injured worker was evaluated on 02/03/2014. The injured worker reported persistent lower back pain with bilateral leg pain and neuropathy. Current medications include Demerol 100 mg, Effexor XR 150 mg, fentanyl 100 mcg/hour, morphine IR 30 mg, Norco 10/325 mg, Protonix 40 mg, Soma 350 mg, Valium 10 mg, and Zolpidem 10 mg. Physical examination revealed tenderness to palpation of the lumbar spine, limited and painful lumbar range of motion, 4/5 strength in the lower extremities, and hypersensitivity in the right lower extremity. Treatment recommendations at that time included continuation of the current medication regimen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Protonix 40 MG Quantity 30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** California MTUS Guidelines state Proton Pump Inhibitors (PPIs) are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a Proton Pump Inhibitor, even in addition to a nonselective NSAID. There is no evidence of cardiovascular disease or increased risk factors for gastrointestinal events. There is also no frequency listed in the current request. As such, the request is non-certified.

**Soma 350 MG Quantity 180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66, 124.

**Decision rationale:** California MTUS Guidelines state Muscle Relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations. Soma should not be used for longer than 2 to 3 weeks. There was no evidence of palpable muscle spasm or spasticity upon physical examination. There is also no frequency listed in the current request. As such, the request is non-certified.

**Valium 10 MG Quantity 90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

**Decision rationale:** California MTUS Guidelines state Benzodiazepines are not recommended for long-term use, because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit the use to 4 weeks. The injured worker does not maintain a diagnosis of an anxiety disorder. The medical necessity for the ongoing use of this medication has not been established. Guidelines do not recommend long-term use of this medication. There is also no frequency listed in the current request. As such, the request is non-certified.

**Zolpidem 10 MG Quantity 30:** 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), Zolpidem (Ambien).

**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 states insomnia treatment is recommended based on etiology. Ambien (Zolpidem) is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker does not maintain a diagnosis of insomnia or sleep disturbance. There is no evidence of a failure to respond to nonpharmacologic treatment prior to the initiation of a prescription product. There is also no frequency listed in the current request. As such, the request is non-certified.