

<b>Case Number:</b>	CM14-0038750		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	07/01/2010
<b>Decision Date:</b>	08/21/2014	<b>UR Denial Date:</b>	03/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2014

### 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 Emergency 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's date of injury is reported as 7/1/2010. The mechanism of the injury is described as being ran over by a forklift. The patient's diagnoses include; Complex Regional Pain Syndrome (CRPS) of the left lower extremity, post fracture to lateral maleolus and 4th metatarsal, degenerative joint disease/impingement syndrome to bilateral shoulder, left hip bursitis, lumbar facet syndrome and depression. Upon viewing the medical records dated 2/20/14 the patient complains of left lower extremity pain, left shoulder pain, left hip pain and left knee pain. The pain level is 8-7/10 and occasionally 10/10. Pain is controlled at 8/10 with pain medications. Quality of sleep is reportedly poor due to pain. The patient reports mild improvement of sleep with medications. Objective exam reveals a minimally responsive, depressed individual. Noted antalgic gait assisted with a cane. Lumbar spine exam reveals; loss of lordosis with straightening, tenderness to palpation to paraspinal muscles and decreased range of motion (ROM). Bilateral shoulder exam reveals; crepitus, pain with range of motion. Movements are restricted by pain. No crepitus, Hawkin's positive and Drop test negative. Tenderness noted to bicep groove and sub-deltoid bursa. The left hip exam reveals; pain and restricted ROM due to pain. Tenderness to trochanter and FABER test is positive. Ankle exam reveals; traumatic changes with medial tibial scarring, tenderness to light touch and dysesthesia noted to left foot and ankle. Straight leg raise is positive of left side. Neurological exam reveals; bilateral 4/5 strength and 3/5 strength in left leg. Due to the pain, the Electromyogram/Nerve Conduction Velocity (12/2010) procedures of the exam were limited revealing incomplete. Urine Drug Screen (10/25/13) shows consistent results. Patient has undergone physical therapy, lumbar epidural steroid injections and medications with little improvement. Medications include ambien, cymbalta, nabumetone, lyrica, avinza and lidoderm patch. Independent Medical Review is for Viagra 50mg #6 x1refill, Ambien 10mg #20; Lidoderm patch 5% #30 and Avinza 60mg #30. Prior Utilization Review on 4/2/14

recommended denial of Viagra, Ambien, Lidoderm and Avinza and approved Lyrica, Cymbalta and Norco.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Viagra 50mg #6 X1 Refill: 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 Other Medical Treatment Guideline or Medical Evidence: MedlinePlus.

**Decision rationale:** There is no sections in the MTUS Chronic pain or ACOEM guidelines or the Official Disability Guide that deals with this topic. As per MedlinePlus, Viagra is indicated and FDA approved for erectile dysfunction. However, patient does not have any diagnosis of erectile dysfunction. As per records, patient has depression and has significantly low mood and low sexual desire. Viagra is not indicated or medically necessary.

#### **Ambien 10mg #20: 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) Chronic Pain and Insomnia Treatment.

**Decision rationale:** There is no specific sections in the MTUS Chronic Pain or ACOEM Guidelines that relate to this topic. Ambien is a Benzodiazepine agonist approved for insomnia. As per Official Disability Guidelines, it recommends treatment of underlying cause of sleep disturbance and recommend short course of treatment. Patient has been on Ambien chronically for almost a year. There is no documentation of other conservative attempts at treatment of sleep disturbance or sleep studies. Patient's sleep problem is noted to be due to pain and depression which should be the primary target for treatment to improve patient's sleep. The chronic use of Ambien is not medically appropriate and is not medically necessary.

#### **Lidoderm 5% Patch #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56-57.

**Decision rationale:** As per MTUS Chronic Pain Guidelines, Lidoderm is only approved for peripheral neuropathic pain, specifically post-herpetic neuralgia. There is poor evidence to support its use in other neuropathic pain conditions such as Complex Regional Pain Syndrome that patient has. It is not medically necessary.

**Avinza 60mg #30:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-79.

**Decision rationale:** Avinza is extended release Morphine. As per MTUS Chronic Pain Guidelines, there are specific guidelines concerning management of chronic pain with Opioids that should be followed while patient is on Opioid therapy. Patient meets criteria for maintenance of Opioids for pain control. The use of Avinza is medically appropriate with appropriate documentation of pain control, side effects and monitoring including urine drug screening. The number of tablets are appropriate for monitoring as well. Avinza is medically necessary.