

<b>Case Number:</b>	CM14-0052337		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	05/31/2006
<b>Decision Date:</b>	08/28/2014	<b>UR Denial Date:</b>	04/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2014

### 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 Nevada. 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 records presented for review indicate that this 62 year-old male was reportedly injured on May 31, 2006. The mechanism of injury is not listed in the records reviewed. The most recent progress note, dated May 19, 2014 indicates that there are ongoing complaints of low back pain. The physical examination demonstrated an individual in no acute distress, with no evidence of motor or sensory losses and deep tendon reflexes are slightly decreased in both lower extremities. Sensation is slightly reduced in the right lower extremity. Diagnostic imaging studies were not noted in recent progress notes. Previous treatment includes multiple medications, injections, and pain management techniques. A request was made for multiple medications and was not certified in the pre-authorization process on April 4, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10mg, no refills #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 Pain (Chronic) 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) pain chapter updated July, 2014.

**Decision rationale:** As outlined in the ODG (ACOEM and MTUS do not address) the indication for this medication is short term, at most, six weeks of intervention is supported. When noting the date of injury, the injury sustained, the chronic indefinite use of this medication there is no clear clinical medical necessity established for the ongoing use of this preparation. Therefore, when following the parameters noted in the MTUS tempered by the clinical records presented by the requesting provider this medication is not medically necessary.

**Ambien 10mg norefills (do not refill until 4/12/14) #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 Pain (Chronic) 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) pain chapter updated July, 2014.

**Decision rationale:** As outlined in the ODG (ACOEM and MTUS do not address) the indication for this medication is short term, at most, six weeks of intervention is supported. When noting the date of injury, the injury sustained, the chronic indefinite use of this medication there is no clear clinical medical necessity established for the ongoing uses preparation. Therefore, when following the parameters noted in the MTUS tempered by the clinical records presented by the requesting provider, this medication is not medically necessary.

**Lyrica 50mg no refills #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19, 99.

**Decision rationale:** As outlined in the MTUS, this medication is indicated for the treatment of a diabetic neuropathy or a post-herpetic neuralgia. Neither malady is noted that this is the clinical situation. An old-label use of this medication is to address neuropathic lesion. Again, the progress notes do not establish a specific neuropathic lesion that this medication is targeting. The last issue is that there is no noted efficacy or utility of this medication. There is no decrease in the pain complaints or increase of the functionality of the injured employee. Therefore, based on each of these parameters the medical necessity for this medication has not been objectified.

**Lyrica 50mg no refills #120 (do not fill until 4/12/14):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19, 99.

**Decision rationale:** As outlined in the MTUS, this medication is indicated for the treatment of a diabetic neuropathy or a post-herpetic neuralgia. Neither malady is noted that this is the clinical situation. An old-label use of this medication is to address neuropathic lesion. Again, the progress notes do not establish a specific neuropathic lesion that this medication is targeting. The last issue is that there is no noted efficacy or utility in of this medication. There is no decrease in the pain complaints or increase in the functionality of the injured employee. Therefore, based on each of these parameters the medical necessity for this medication has not been objectified.

**Tizanidine 4mg #30 1 refill QTY 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine- Zanaflex muscle relaxant.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-spasticity/Anti-spasmodic drugs Page(s): 66.

**Decision rationale:** As outlined in the MTUS, this medication is indicated for the management of spasticity. This is unlabeled for use in low back pain. And there are no clinical indicators of a specific situation and that there are ongoing complaints of low back pain. The parameters noted in the MTUS are not met as such and the medical necessity for the ongoing use of this medication has not been established. Therefore, this request is not medically necessary.