

<b>Case Number:</b>	CM15-0008987		
<b>Date Assigned:</b>	01/27/2015	<b>Date of Injury:</b>	08/15/1988
<b>Decision Date:</b>	03/16/2015	<b>UR Denial Date:</b>	12/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/15/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New York  
 Certification(s)/Specialty: Anesthesiology

### 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 63 year old female, who sustained a work/ industrial injury on 8/15/88. She has reported symptoms of left sided buttock and leg pain. The diagnoses have included degenerative disc disease of the lumbar spine with multilevel spondylosis and left-sided lumbar radiculopathy. A left hemilaminectomy with L5-S1 fusion were performed on 8/7/90. Treatments have included medications, including Dilaudid, Ambien, for greater than 6 months, diagnostic facet injections at L2-S1, and surgery. The physician requested Ambien for insomnia, Baclofen for spasms, Nexium for gastrointestinal prophylaxis, and lumbar radiofrequency at L2-S2 treatments after having received the facet injections. On 12/18/14, Utilization Review non-certified Ambien CR 12.5 mg (unspecified); Baclofen (unspecified); Nexium 40 mg (unspecified); and Lumbar Radiofrequency L2-S2, noting the Medical treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines (ODG) Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien CR 12.5mg (Unspecified): 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 Chronic Pain Chapter, Mental Illness & Stress, Insomnia

**Decision rationale:** Ambien CR 12.5 mg (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is recommended for short-term treatment of insomnia (two to six weeks). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien CR to be effective for up to 24 weeks in adults. This can be habit-forming, and may impair function and memory more than opioid analgesics. There is also concern that Ambien may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology, and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case, Ambien CR has been used for greater than 6 months. There is no documentation indicating if the patient uses this medication every night, or on an as needed basis. There is no documentation provided indicating medical necessity for Ambien CR. The requested item is not medically necessary.

**Baclofen (unspecified):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity Drugs Page(s): Page 64.

**Decision rationale:** The mechanism of action for Baclofen is blockade of the pre- and post-synaptic GABA receptors. It is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. It is also a first-line option for the treatment of dystonia. Baclofen has been noted to have benefits for treating lancinating, paroxysmal neuropathic pain. There is no documentation provided necessitating the use of Baclofen. Medical necessity for the requested medication has not been established. The requested item is not medically necessary.

**Nexium 40mg (unspecified):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Prilosec (Nexium). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Proton Pump Inhibitors (PPIs)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS, NSAIDs, GI symptoms & cardiovascular risk Page(s): 68. Decision based on Non-MTUS Citation Proton Pump Inhibitors

**Decision rationale:** According to CA MTUS (2009), proton pump inhibitors, such as Nexium, are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. This patient is not currently taking an NSAID. Based on the available information provided for review, the medical necessity for Nexium has not been established. The requested medication is not medically necessary.

### **Lumbar Radiofrequency L2-S2: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 300-301, 196-199. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Facet Joint Radiofrequency Neurotomy

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Low Back Chapter

**Decision rationale:** Medial branch blocks (MBBs) and radiofrequency ablations (RFA) are accepted pain management interventional techniques. However, specific criteria and standards of care apply for performing these procedures. According to the ODG, the criteria for the use of therapeutic medial branch blocks are as follows: 1) no more than one therapeutic intra-articular block is recommended. 2) There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3) If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of 6 weeks) the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block (MMB) is positive). 4) No more than 2 joint levels may be blocked at any one time. In this case, the injured worker had left-sided radicular pain and is S/P hemilaminectomy with fusion L5-S1, which do not meet the ODG recommendations for facet joint blocks or to be subsequently followed by facet joint rhizotomy (or radiofrequency neurotomy). The documentation indicated that the patient did undergo a prior MBB at L2-S1 with reported immediate 90% pain relief. However, guidelines support RFA at only 2 levels, and not at multiple levels as were previously done. In addition, the documentation submitted for review provided evidence of radiculopathy and a previous lumbar fusion (L5-S1) in the same area as the RFA request. The request as submitted, does not support the evidence based guidelines. As such, the request for radiofrequency ablation (L2-S1) is not medically necessary. Medical necessity for the requested service has not been established.