

<b>Case Number:</b>	CM15-0130005		
<b>Date Assigned:</b>	07/16/2015	<b>Date of Injury:</b>	11/04/1999
<b>Decision Date:</b>	08/21/2015	<b>UR Denial Date:</b>	06/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/06/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 42 year old female who sustained an industrial injury on 11/04/1999 when her fingers were caught in a conveyor roller. The injured worker was diagnosed with post lumbar laminectomy syndrome, lumbar radiculopathy and reflex sympathetic dystrophy syndrome (RSD) right upper and lower limb. The injured worker is status post lumbar surgery (no date or procedure documented); spinal cord stimulator (SCS) in December 2000 and intrathecal pump (no date documented). Treatments documented to date have included diagnostic testing, surgery, intrathecal pump implant right flank, spinal cord stimulator implant right axilla and medications. According to the primary treating physician's progress report on June 17, 2015, the injured worker continues to experience arm pain, back and shoulder pain and headaches. The injured worker rates her pain level at 9/10. The injured worker presents for intrathecal pump refill of 20ml of Dilaudid 20mg/ml, Clonidine 10mcg/ml and Baclofen 80mcg/ml. This is a 10% decrease to 3.004mg/day until revision surgery is authorized. According to the medical report on May 5, 2015, the injured worker was noted to have symptoms of under and over medicating with redness over the implant site. The injured worker reported intermittent nausea, headaches, insomnia, anxiety and excessive sleepiness with increased pain of the lower back. Examination noted edema, erythema and allodynia at the lumbar pump site. Catheter was poorly visualized on fluoroscopy, pump interrogation performed and decision to titrate intrathecal pump medications was deemed necessary. There was noted tenderness at the lumbar incision line. Range of motion was noted to be decreased on extension. Right arm allodynia and dysesthesia were also noted. Current oral medications are listed as Percocet 10/325mg, Provigil, Baclofen, Valium and

Ambien. Treatment plan consists of intrathecal pump replacement and the current request for Provigil, Baclofen and Ambien.

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

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

**Provigil 200 MG #30 with 1 Refill:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation PDR, provigil.

**Decision rationale:** The ACOEM, ODG and the California MTUS do not specifically address the requested service as prescribed. The physician desk reference states the requested medication is indicated in the treatment of narcolepsy, shift-work disorder and excessive daytime somnolence disorder. The patient does not have any of these documented diagnoses as directly due to industrial incident. Therefore the request is not medically necessary.

**Baclofen 10 MG #90 with 1 Refill:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-65.

**Decision rationale:** The California chronic pain medical treatment guidelines section on muscle relaxants states: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (Van Tulder, 2003) (Van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) (Chou, 2004) This medication is not intended for long-term use per the California MTUS. The medication has not been prescribed for the flare-up of chronic low back pain. This is not an approved use for the medication. For these reasons, criteria for the use of this medication have not been met. Therefore the request is not medically necessary.

**Ambien 5 MG #30 with 1 Refill:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ambien.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address the requested medication. Per the ODG: Zolpidem is a prescription short-acting non-benzodiazepine hypnotic approved for the short-term treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain. While sleeping pills, so-called minor tranquilizers and anti-anxiety medications are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. There is also concern that they may increase pain and depression over the long-term. The medication is not intended for use greater than 6 weeks. There is no notation or rationale given for longer use in the provided progress reports. There is no documentation of other preferred long-term insomnia intervention choices being tried and failed. For these reasons the request is not medically necessary.