

<b>Case Number:</b>	CM15-0137929		
<b>Date Assigned:</b>	07/27/2015	<b>Date of Injury:</b>	10/15/2007
<b>Decision Date:</b>	09/18/2015	<b>UR Denial Date:</b>	07/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/16/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 59-year-old female, who sustained an industrial injury on 10/15/2007. The mechanism of injury is unknown. The injured worker was diagnosed as having left Achilles tendon repair, gait derangement and cane dependence. There is no record of a recent diagnostic study. Treatment to date has included therapy and medication management. In a progress note dated 6/16/2015, the injured worker complains of dull throbbing ankle pain. Physical examination stated no change. The treating physician is requesting 12 additional weeks of [REDACTED], unspecified creams, Ambien and Voltaren (dosages unspecified).

### IMR ISSUES, DECISIONS AND RATIONALES

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

[REDACTED] (More Weeks), QTY: 12: 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 The Practical Guide: Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, NIH Publication No. 00-4084, October 2000.

**Decision rationale:** The MTUS Guidelines does not address weight loss programs as medically necessary treatment. The cited guidelines do not address any specific weight loss program such as [REDACTED]. Although interventions for weight loss may be indicated, and are supported by the cited guidelines, there is no indication that any consumer based weight loss program would be more beneficial than a program designed by the treating physician, or by a primary care provider. The cited guidelines provide the essential elements for primary care providers to direct patients to healthy weight loss. Additionally, the injured worker has recently participated in a commercial weight loss program without documentation of its efficacy, therefore, the request for [REDACTED] (More Weeks), QTY: 12 is determined to not be medically necessary.

**Creams (Name, Dosage, Quantity Unspecified), QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111-113.

**Decision rationale:** The MTUS Guidelines recommend the use of topical analgesics as an option for the treatment of chronic pain, however, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. In this case, there is not a specific medication, dosage, or quantity information included with this request, therefore, the request for creams (name, dosage, quantity unspecified), QTY: 1 is determined to not be medically necessary.

**Ambien (Dosage/Quantity Unspecified), QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG), Pain, 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/Insomnia Section.

**Decision rationale:** The MTUS Guidelines do not address the use of zolpidem. Per the Official Disability Guidelines, pharmacological agents should only be used for insomnia management after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically whereas secondary insomnia may be treated with pharmacological and/or psychological measures. Zolpidem reduces sleep latency and is indicated for the short-term treatment (7-10 days) of insomnia with difficulty of sleep onset and/or sleep maintenance. Adults who use zolpidem have a greater than 3-fold increased risk for early death. Due to adverse effects, FDA now requires lower doses for zolpidem. The dose for women should be reduced from 10 mg to 5 mg for immediate release products and from 12.5 mg to 6.25 mg for extended release products. The medical records do not address the

timeline of the insomnia or evaluation for the causes of the insomnia. The medical records do not indicate that non-pharmacological modalities such as cognitive behavioral therapy or addressing sleep hygiene practices prior to utilizing a pharmacological sleep aid. Ambien has been used for an extended period without evidence of an improvement in sleep patterns. Additionally, there is no dosage or quantity information included with this request. The request for Ambien (dosage/quantity unspecified), QTY: 1 is determined to not be medically necessary.

**Voltaren (Dosage/Quantity Unspecified), QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Diclofenac (Voltaren) Page(s): 71.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111-113.

**Decision rationale:** Per the MTUS Guidelines, the use of topical analgesics is recommended as an option for some agents. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Voltaren Gel 1% is FDA approved and indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). In this case, there is no dosage or quantity information included with this request and the injured worker has been using NSAIDs in a chronic nature, which is not supported by the established guidelines. The request for Voltaren (dosage/quantity unspecified), QTY: 1 is determined to not be medically necessary.