

<b>Case Number:</b>	CM15-0206402		
<b>Date Assigned:</b>	10/23/2015	<b>Date of Injury:</b>	11/19/2013
<b>Decision Date:</b>	12/14/2015	<b>UR Denial Date:</b>	10/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2015

### 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, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency 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 58 year old male, who sustained an industrial injury on November 19, 2013, incurring right knee, bilateral shoulders, low back and left knee injuries. He was diagnosed with end stage osteoarthritis of the right knee, arthritis of the left knee, lumbar radiculopathy, lumbar degenerative disc disease, and shoulder strains. Treatment included pain medications, nerve blocks, exercise program, occupational therapy, anti-inflammatory drugs, steroid injections, bracing, topical analgesic creams, multiple knee arthroscopic surgeries and activity restrictions. On May 5, 2015, the injured worker underwent a right total knee replacement. Currently, the injured worker complained of persistent lower back, shoulder pain and bilateral knee pain rated 7 out of 10 on a scale of 1 to 10 with medications. He noted difficulty sleeping secondary to chronic pain. His range of motion in the lumbar region was limited by pain and extension with persistent muscle spasms. He was limited with his range of motion in both shoulders and bilateral knees. The chronic pain and persistent muscle spasms interfered with all activities of daily living including self-care, sleeping, walking, sitting and standing. The treatment plan that was requested for authorization included prescriptions for Ambien 10 mg #30 with 2 refills and Voltaren 1% with 2 refills. On October 13, 2015, a request for prescriptions for Ambien and Voltaren were denied by utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10mg #30 with 2 refills: 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 Chapter, 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) Treatment of insomnia.

**Decision rationale:** Guidelines recommend short term use of sleep agents only after careful evaluation of potential causes of sleep disturbance. The guidelines further state the failure of sleep disturbances to resolve in 7-10 days may indicate a medical or psychiatric illness. In this case, there is no documentation of behavioral treatments that have been attempted and response to non-pharmacologic measures. The request for Ambien 10 mg #30 with 2 refills is not medically appropriate and necessary.

**Voltaren 1% x 1 with 2 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Guidelines state that topical agents are largely experimental and that Voltaren gel is primarily recommended for relief of osteoarthritis pain. In this case, there was no evidence of osteoarthritis pain and no indication that the patient is unable to tolerate oral NSAIDs. The request for topical Voltaren 1% with 2 refills is not medically appropriate and necessary.