

<b>Case Number:</b>	CM15-0064263		
<b>Date Assigned:</b>	06/05/2015	<b>Date of Injury:</b>	08/20/2002
<b>Decision Date:</b>	07/03/2015	<b>UR Denial Date:</b>	03/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/04/2015

### 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 63 year old who sustained an industrial injury on 08/20/2002. Diagnoses include L4-L5 and 5-S1 intervertebral disc disease with annular tears, cervical spondylosis, chronic pain syndrome, gastroesophageal reflux disease, sleep disturbance, bilateral shoulder internal derangement, right rotator cuff tear, lateral epicondylitis, left thumb trigger finger, left carpal/cubital tunnel syndrome and status post left carpal tunnel release. Treatment to date has included diagnostic studies; status post left carpal tunnel release, and medications. A physician progress note dated 02/19/2015 documents the injured worker has completed left carpal tunnel release. He has been provided with a recent shoulder injection for impingement. His gait is cane assisted. Cervical spine range of motion is limited with moderate tenderness and positive axial head compression test. The lumbar spine remains diffusely tender with painful range of motion and flexion is limited to 40 degrees with referred back pain and hamstring tightness bilaterally with straight leg raise. A urinary drug screen is consistent with present medicine regime. The treatment plan includes discontinuation of Nortriptyline and Trazadone, continue Lyrica for chronic pain symptoms, continue Lidoderm patches, continue Prilosec, renew Ambien and Hydrocodone and Wellbutrin XL, and request home cervical traction unit. A physician progress note dated 03/12/2015 documents the injure worker is unchanged. He is having continued hand complaints and is awaiting hand therapy. Treatment requested is for Ambien 10mg #30, and Lyrica 100mg #90. There is a concurrent prescription for Neurontin written by the treating Orthopedist.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10mg #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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain - Insomnia Treatment.

**Decision rationale:** MTUS Guidelines do not address this issue. ODG Guidelines address this issue and updated versions of the Guidelines are supportive of the long term use of specific hypnotic agents for chronic insomnia associated with chronic pain. However, Ambien is not one of the drugs supported for long term use. Guidelines recommend use be limited to 3 weeks and chronic use avoided. There are alternatives recommended and there are no unusual circumstances to justify an exception to Guidelines. The Ambien 10mg. #30 is not supported by Guidelines and is not medically necessary.

**Lyrica 100mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anit-epilepsy drugs Page(s): 16-19.

**Decision rationale:** MTUS Guidelines supports the use of Lyrica for neuropathic pain when certain standards are met. These Guideline standards include a recommendation that the amount of pain relief be quantified and functional outcomes be measured to support ongoing use. These standards are not met as there are no measured pain or functional benefits documented to justify its on-going use. Additional specific documentation could support ongoing use. In addition, another drug (Gabapentin) from the same class has been initiated by the treating orthopedist and there is no acknowledgement of this by the pain management physician. Under these circumstances the Lyrica 100mg. #90 is not supported by Guidelines and is not medically necessary.