

<b>Case Number:</b>	CM14-0121014		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	06/03/1999
<b>Decision Date:</b>	10/31/2014	<b>UR Denial Date:</b>	07/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/31/2014

### 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. The expert reviewer is Board Certified in Pain Management and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 71-year-old female who sustained an injury on June 3, 1999. She is diagnosed with (a) lumbar radiculopathy, (b) cervical radiculopathy, (c) cervical disc degeneration, (d) depression, (e) deconditioned state, (f) osteoarthritis, (g) chronic pain, (h) bilateral knee pain, (i) status post open heart surgery, (j) status post lap band removal, (k) anemia, (l) chronic abdominal pain, and (m) status post left knee surgery. She was seen for an evaluation on August 5, 2014. She had complaints of low back pain with radiation to the bilateral lower extremities, neck pain with radiation to the bilateral upper extremities, and right foot pain. She also reported activity of daily living limitations in areas of hygiene, activity, ambulation, and sleep. Examination of the lumbar spine revealed spinal vertebral tenderness over the L4-S1 level. Lumbar myofascial tenderness was also noted. Range of motion was moderately reduced secondary to pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Restone 3- 100mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation THE OFFICIAL DISABILITY GUIDELINES STATES THAT "IT IS RECOMMENDED THAT TREATMENTS FOR INSOMNIA SHOULD REDUCE TIME TO SLEEP ONSET, IMPROVE SLEEP MAINTENANCE, AVOID RESIDUAL EFFECTS, AND INCREASE NEXT DAY FUNCTIONING."

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

**Decision rationale:** The request for Restone 3-100 mg #60 is not medically necessary at this time. Based on the reviewed medical records, the injured worker failed conservative sleep aid modalities and reported improved sleep quality and duration with Restone. However, there was no documentation of objective functional improvement as a result of taking this medication. Hence, the request for Restone 3-100 mg #60 is not medically necessary at this time.