

<b>Case Number:</b>	CM14-0098341		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	05/15/2000
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	06/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/26/2014

### 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 Physical Medicine and Rehabilitation, and Pain Medicine, and is licensed to practice in California and Washington. 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 57-year-old male who reported an injury on 05/15/2000. The mechanism of injury was not stated. Current diagnoses include failed back syndrome, unspecified internal derangement of the knee, status post total knee replacement revision, cervical radiculopathy, lumbar radiculopathy, and fibromyalgia/myositis. Previous conservative treatment includes chiropractic therapy and medication management. The current medication regimen includes baclofen 20 mg, Duragesic 25 mcg, Lyrica 150 mg, Percocet 10/325 mg, Voltaren gel, Lidoderm 5% patch, and Ambien 10 mg. The injured worker was evaluated on 08/07/2014 with complaints of ongoing neck and lower back pain. The physical examination revealed positive straight leg raising bilaterally, facet tenderness at L3-S1, positive trigger points with a twitch response, an antalgic gait, limited lumbar range of motion, and diminished strength in the right lower extremity. The treatment recommendations at that time included continuation of the current medication regimen. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien CR 12.5mg #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 (ODG), Zolpidem

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

**Decision rationale:** The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset. The injured worker does not maintain a diagnosis of insomnia or sleep disturbance. The injured worker has also utilized this medication since 11/2013 without any evidence of functional improvement. There is also no frequency listed in the request. As such, the request is not medically appropriate.

**Baclofen 20mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** The California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. Efficacy appears to diminish over time and prolonged use may lead to dependence. The injured worker has continuously utilized this medication since 11/2013 without any evidence of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically appropriate.

**Lidoderm 5% patch #90 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine Patch).

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

**Decision rationale:** The California MTUS Guidelines state lidocaine is indicated for neuropathic pain or localized peripheral pain after there has been evidence of a trial of first line treatment with antidepressants and anticonvulsants. The injured worker has continuously utilized this medication since 11/2013 without any evidence of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically appropriate.