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| <b>Case Number:</b>   | CM15-0012120 |                              |            |
| <b>Date Assigned:</b> | 01/29/2015   | <b>Date of Injury:</b>       | 11/27/1996 |
| <b>Decision Date:</b> | 03/26/2015   | <b>UR Denial Date:</b>       | 01/15/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/21/2015 |

### 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: California, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 62-year-old male who reported an injury on 11/27/1996. The mechanism of injury was the injured worker felt pain in the low back while attempting to dislodge a dolly from a groove between a truck and a floor. The injured worker was noted to have diagnoses of low back pain, chronic, failed back surgery, lumbar radiculopathy, myalgia, xerostomia, shoulder impingement syndrome bilaterally, erectile dysfunction secondary to medications, testicular hypofunction secondary to opioid use, anxiety and depression. Prior therapies included medications and surgery. The documentation of 01/07/2015 revealed the injured workers purpose of the visit was medication management. The pain was noted to be in the bilateral legs, shoulders, buttocks, knees, and low back. There was no change in pain. The injured worker's pain with medications was 4/10. In the last month without medications, it was noted to be not applicable. The current medications included Ambien 10 mg 1 daily for insomnia, Ambien 12.5 mg 1 daily as needed for insomnia, Cymbalta 60 mg 2 capsules daily, and Naprosyn 500 mg 1 tablet twice a day as needed for inflammation or minor pain. Prescriptions were written for the same medications. The injured worker was noted to have a kyphotic posture with a slow, antalgic gait and to transition gingerly. The injured worker was utilizing a single point cane. The injured worker was to undergo a urine drug screen on the next visit. The injured worker had utilized the medications since at least 11/2014. There was no Request for Authorization submitted for review.

### 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, Treatment Index, 11th Edition (web), 2014, Pain

**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, Zolpidem.

**Decision rationale:** The Official Disability Guidelines indicate that Ambien is recommended for the short term treatment of insomnia of up to 10 days. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for an extended duration of time. The objective functional benefit was not provided. The request as submitted failed to indicate the frequency for the requested medication and there was a lack of documentation indicating a necessity for both Ambien 10 mg and Ambien 12.5 mg. Given the above and the lack of documentation of exceptional factors, the request for Ambien 10 mg #30 is not medically necessary.

**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, Treatment Index, 11th Edition (web), 2014, Pain

**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, Zolpidem.

**Decision rationale:** The Official Disability Guidelines indicate that Ambien is recommended for the short term treatment of insomnia of up to 10 days. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for an extended duration of time. The objective functional benefit was not provided. The request as submitted failed to indicate the frequency for the requested medication and there was a lack of documentation indicating a necessity for both Ambien 10 mg and Ambien 12.5 mg. Given the above and the lack of documentation of exceptional factors, the request for Ambien CR 12.5 mg #30 is not medically necessary.

**Cymbalta 60mg # 60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 15-16.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants Page(s): 13.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend antidepressants as a first line medication for the treatment of neuropathic pain. They are recommended especially if the pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective functional improvement to include an assessment of the changes in the use of other analgesic medications, sleep quality and duration, and psychological assessments. The clinical documentation submitted for review failed to meet the above criteria. There was a lack of documentation of objective functional improvement and an objective decrease in pain, as well as an assessment in the changes of the use of other analgesic medications, sleep quality and duration, and psychological assessment. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Cymbalta 60 mg #60 is not medically necessary.

**Naprosyn 500mg # 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-70.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDs are recommended for the short term symptomatic relief of low back pain. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to indicate the injured worker had objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Naprosyn 500 mg #60 is not medically necessary.