

<b>Case Number:</b>	CM15-0042387		
<b>Date Assigned:</b>	03/12/2015	<b>Date of Injury:</b>	07/23/2012
<b>Decision Date:</b>	05/14/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2015

### 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: 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 male who reported an injury on 0/23/2012 due to an unspecified mechanism of injury. On 12/17/2015, he presented for a follow up evaluation regarding his work related injury. He complained of left upper extremity pain, as well as neck pain. He noted that the pain felt tight and spastic in the neck. He reported undergoing a trigger point injection that helped 70% of his pain and lowered his medication dose. On examination, he had left trapezius trigger points and tenderness to palpation with a positive twitch sign upon palpation. There was an MCP joint deformity and diffuse allodynia to the left upper extremity with atrophy. He was diagnosed with status post puncture wound, secondary left upper extremity CRPS, and status post left thumb tendon surgery. The injured worker's medications at the time included tizanidine 4 mg at bedtime, Lyrica 150 mg twice a day, Ambien 10 mg at bedtime for sleep, and tramadol every 8 hours as needed. The treatment plan was for the injured worker to continue his medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tizanidine 4mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

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

**Decision rationale:** The California MTUS Guidelines recommend non-sedating muscle relaxants as a short term treatment option for low back pain. The documentation provided does not indicate that the injured worker is suffering from low back pain or that he has failed first line therapy medications to support the request. Also, further clarification is needed regarding how long he has been using this medication as it is only recommended for short term treatment. In addition, the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

**Lyrica 100mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Specific Antiepilepsy Drugs Page(s): 19 and 20.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin (Lyrica) Page(s): 99.

**Decision rationale:** The California MTUS Guidelines indicate that Lyrica is only recommended and FDA approved for diabetic neuropathy and postherpetic neuralgia. The documentation provided does not show that the injured worker has a diagnosis of diabetic neuropathy or postherpetic neuralgia to support the medical necessity of this medication. There is also no indication that he has a quantitative decrease in pain or an objective improvement in function with use. Furthermore, the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

**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 (ODG) (updated 2/23/15).

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

**Decision rationale:** The Official Disability Guidelines indicate that Ambien is recommended for the short term treatment of insomnia of no longer than 7 to 10 days. The documentation provided does not indicate that the injured worker has a diagnosis of insomnia to support this medication. Also, there is no indication that he had a quantitative decrease in pain or objective improvement in function with use. Furthermore, it is unclear how long he has been using this medication and the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

**Tramadol 50mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, opioids criteria for use, weaning of medications Page(s): 93, 94, 78-80 and 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going management Page(s): 78.

**Decision rationale:** The California MTUS guidelines indicate that an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be performed during opioid therapy. The documentation provided fails to show that the injured worker has had a quantitative decrease in pain or an objective improvement in function with this medication. There were also no official urine drug screens or CURES reports provided for review to validate that he has been compliant with his medication regimen. Without this information, continuing this medication would not be supported. Furthermore, frequency was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.