

<b>Case Number:</b>	CM15-0099423		
<b>Date Assigned:</b>	06/01/2015	<b>Date of Injury:</b>	01/15/2009
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	05/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/22/2015

### 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: New Jersey, New York  
 Certification(s)/Specialty: Family Practice

### 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 (IW) is a 36-year-old female who sustained an industrial injury on 01/15/2009 due to a fall. Diagnoses include left knee patellar tendinitis, right knee arthropathy with internal derangement and reactive depression and anxiety. Treatment to date has included medications, heat/ice, knee surgeries, chiropractic treatment and physical therapy. The Initial Evaluation dated 2/3/15 stated an MRI of the right knee showed anterior cruciate ligament injury and disruption at the medial meniscus and electrodiagnostic testing of the bilateral upper and lower extremities showed current bilateral L4-5 radiculopathy and evidence consistent with bilateral carpal tunnel syndromes. According to the PR2 dated 4/21/15, the IW reported continued right knee pain with swelling. Her right knee gave way and she fell the week before this appointment. On examination, she walked with a cane and her gait was antalgic. The right knee was tender to palpation over the lateral and medial joint lines and peripatellar area. There was "give way" weakness with flexion and extension of the right knee. Mild swelling of the right knee was noted as was deep flexion pain. Reflexes were negative in the knees, bilaterally. A request was made for Percocet 10/325mg, Ambien 10mg, Xanax, Zoloft and Lidoderm patches for her pain and what the provider refers to as "psychiatric overlay".

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Percocet (unknown quantity or duration): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-79.

**Decision rationale:** The request is not medically necessary. The chart does not provide any recent quantifiable objective documentation of improvement in pain (e.g. decrease in pain scores) and function with the use of percocet, Urine drug screen were not included in the chart. There are no drug contracts included in the chart or long-term goals for treatment. The 4 A's of ongoing monitoring were not adequately documented. There was no evidence of objective functional gains with the use of Percocet. The quantity and duration need to be documented. Therefore, the request is not medically necessary.

**Ambien (unknown quantity or duration): 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).

**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, Ambien.

**Decision rationale:** The request for Ambien is not medically necessary. MTUS guidelines do not address the use of Ambien. As per ODG, Ambien is a hypnotic that is approved for short-term treatment of insomnia, from 2-6 weeks. It can be habit-forming and may impair function and memory. It may also increase pain and depression over the long-term. There is no documentation that patient has failed a trial of proper sleep hygiene. The risk of long-term use of Ambien currently outweighs benefit and is not medically necessary.

**Xanax (unknown quantity or duration): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** The request for Xanax is not medically necessary. Xanax is a benzodiazepine, which is not recommended for long-term use because of lack of evidence. They are used as sedative/hypnotics, anxiolytics, anticonvulsants, and muscle relaxants. There is a risk of physical and psychological dependence and addiction to this class. Guidelines limit the use to four weeks. The patient is being treated for anxiety and depression. According to MTUS, continued use of antidepressants is an appropriate treatment for anxiety disorders. Therefore, the request is not medically necessary.

**Zoloft (unknown quantity or duration): Upheld**

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

Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 16.

**Decision rationale:** The request would have been considered medically necessary given the patient's diagnosis of anxiety and depression. Zoloft is a selective serotonin reductive inhibitor effective for the treatment of mood disorders. However, because quantity and duration were not noted, the request is not medically necessary.

**Lidoderm patches (unknown quantity or duration):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm, topical analgesics Page(s): (s) 56-57, 111-112.

**Decision rationale:** The request is not medically necessary. According to MTUS guidelines, Lidoderm is not first line treatment and is only FDA approved for post-herpetic neuralgia. More research is needed to recommend it for chronic neuropathic pain other than post-herpetic neuralgia. The quantity and duration was also not specified. Therefore, the request is considered medically unnecessary.