

Case Number:	CM13-0054918		
Date Assigned:	12/30/2013	Date of Injury:	04/04/1990
Decision Date:	04/03/2014	UR Denial Date:	11/08/2013
Priority:	Standard	Application Received:	11/20/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Pulmonary Diseases, 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 physician 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 patient is a 70-year-old male who reported an injury on 04/04/1990. The mechanism of injury was not provided for review. The patient developed a chronic low back pain. The patient's most recent clinical evaluation documented that the patient had an average pain rated at a 7/10 that was consistent with or without medications. The patient's medication schedule included Norco 10/325 mg, ibuprofen 800 mg, Xanax 0.25 mg, Ambien 10 mg, Lyrica 50 mg, Effexor XR 150 mg, Protonix 20 mg, Lidoderm patches, and aspirin tablets. The patient's most recent clinical evaluation described the patient as having an antalgic gait without the use of an assistive device, with a positive straight leg raising test bilaterally, and restricted lumbar range of motion secondary to pain, with decreased sensation in the L4, L5, and S1 dermatomes, and decreased motor strength in the L4, S1 dermatomes. The patient's diagnoses included back pain of the lumbar spine with radiculopathy, degenerative disc disease of the lumbar spine, depression, anxiety, and insomnia. The patient's treatment plan included continuation of medication usage, continuation of monitoring the patient for noncompliant behavior, continuation of a home exercise program, and an additional epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm 5% Patch (Lidocaine):

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The requested Lidoderm 5% is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the continued use of Lidoderm patches be supported by documentation of functional improvement and a quantitative assessment of pain relief. The clinical documentation submitted for review indicates that the patient has an average pain of 7/10 that is not affected by medication usage. Additionally, the clinical documentation fails to provide any evidence of significant functional benefit related to this medication. As such, the requested Lidoderm 5% patch is not medically necessary or appropriate.

Xanax 0.25mg (Alprazolam): Upheld

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

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

Decision rationale: The requested Xanax 0.25 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend the long-term use of benzodiazepines, as there is a significant risk for psychological and physical dependence. The clinical documentation submitted for review does indicate that the patient has been on this medication for an extended duration of time. Therefore, continued use would not be supported. As such, the requested Xanax 0.25 mg is not medically necessary or appropriate.

Lyrica 50mg (Pregabalin): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Medications for Chronic Pain and Antiepilepsy drugs (AEDs) Page(s): 60, 16.

Decision rationale: The requested Lyrica 50 mg is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of anti-convulsants as a first-line treatment for the management of chronic pain. However, California Medical Treatment Utilization Schedule also recommends the continued use of medications in the management of chronic pain be supported by documentation of functional benefit and a quantitative assessment of significant pain relief. The clinical documentation submitted for review indicates that the patient has an average pain of 7/10 that is not affected by medication usage. Additionally, the clinical documentation does not provide any specific evidence of functional benefit as a result of medication usage. Therefore, continued use of this medication

would not be supported. As such, the requested Lyrica 50 mg is not medically necessary or appropriate.

Ambien 10mg (Zolpidem Tartrate): 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) Pain Chapter.

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, Insomnia Treatments

Decision rationale: The requested Ambien 10 mg is not medically necessary or appropriate. Official Disability Guidelines do not recommend the long-term use of this medication. The clinical documentation submitted for review does indicate that the patient has been taking this medication for an extended duration of time. Therefore, continued use would not be supported. As such, the requested Ambien 10 mg (zolpidem tartrate) is not medically necessary or appropriate.