

Case Number:	CM14-0013180		
Date Assigned:	02/24/2014	Date of Injury:	01/29/2009
Decision Date:	07/21/2014	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	02/03/2014

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 Occupational Medicine, 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 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 patient is a 59-year-old female who has submitted a claim for lumbar post-laminectomy syndrome, neuralgia/neuritis, lumbar spinal stenosis and lumbosacral spondylosis, associated with an industrial injury date of January 29, 2009. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of back pain and sacroiliac discomfort. Physical examination revealed an antalgic gait in the left. Sensation was reduced in the L4-L5 dermatome. Allodynia and hypesthesia were noted in the left lower extremity. Muscle strength was 5/5 bilaterally in the lower extremities. Left patellar reflex was hypoactive. Treatment to date has included lumbar surgery 10/18/11, epidural steroid injections, facet joint rhizotomy, physical therapy, and medications, which include Soma 350mg, Percocet 1/325, Zolpidem 10mg, Prilosec 2mg, Diclofenac 100mg and Voltaren gel. Utilization review from January 27, 2014 denied the request for Zolpidem 10mg #30 because the patient's sleep complaints were not documented. The request for Voltaren gel #1 was also denied because ODG does not recommend use of topical NSAIDs for treatment of chronic low back pain or neuropathic pain. Medical necessity was not established for the requested Voltaren gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

ZOLPIDEM 0MG #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) Pain Chapter, Insomnia Treatment, Zolpidem.

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 Treatment, Zolpidem.

Decision rationale: CA MTUS does not specifically address Zolpidem. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. While sleeping pills are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming and they may impair function and memory. There is also concern that they may increase pain and depression over the long term. In this case, the patient's initial intake of Zolpidem is not known, but the earliest record of intake was from a progress report dated 5/21/13. Medical records do not document any sleep problems. No objective functional gains from Zolpidem use were noted. Furthermore, guidelines recommend short term use only. Medical necessity has not been established. Therefore, the request for Zolpidem 10mg #30 is not medically necessary.

VOLTAREN GEL #1: 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, Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines 9792.24.2, Topical Analgesics Page(s): 112.

Decision rationale: According to page 112 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Voltaren Gel 1% (Diclofenac) is indicated for relief of osteoarthritic pain in joints that lend themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of spine, hip, or shoulder. In this case, the earliest documented use of Voltaren was from a progress report dated 5/21/13. However, there was no documentation of functional gains such as improved ability to perform activities of daily living associated with its use. There is likewise no evidence of intolerance to oral medications. There is no clear indication for continued use of this medication. The medical necessity was not established. Therefore, the request for Voltaren Gel #1 is not medically necessary.