

Case Number:	CM14-0152375		
Date Assigned:	09/22/2014	Date of Injury:	05/26/2004
Decision Date:	10/23/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/18/2014

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 Physical Medicine and Rehabilitation and Pain 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 injured worker is a 60-year-old male who reported an injury on 05/26/2004. The mechanism of injury was a fall. The diagnoses included chronic pain, lumbar disc displacement, lumbar facet arthropathy, lumbar radiculopathy, status post fusion of the lumbar spine, peripheral neuropathy, anxiety, and status post spinal cord stimulator implant. Previous treatments included surgery, medication, x-rays, EMG/NCV and spinal cord stimulator implant. Within the clinical note dated 08/25/2014 it was reported the injured worker complained of low back pain. The pain radiated down the bilateral lower extremities. The pain was aggravated by activity and walking. The injured worker reported insomnia with ongoing pain. He rated his pain 8/10 in severity. Upon physical examination the provider noted the injured worker had spasms of the bilateral paraspinal musculature. Tenderness was noted upon palpation in the spinal vertebral at L4-S1 levels. The range of motion of the lumbar spine was moderately to severely limited by pain. The provider requested Ambien, AndroGel and Lidoderm. However, a rationale was not submitted for clinical review. The Request for Authorization was not submitted for clinical 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 (ODG), Pain, Zolpidem (Ambien)

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 request for Ambien 10mg, #30 is not medically necessary. The Official Disability Guidelines note zolpidem as a prescription short acting nonbenzodiazepine hypnotic, which was approved for the short term, usually 2 to 6 weeks treatment of insomnia. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

AndroGel 1%, (5g) gel packet (50mg/5g) #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 110. Decision based on Non-MTUS Citation Article Delayed Puberty in Male and Hypogonadism, J Clin Endocrinol Metab. 2010 Jun; 95(6);2536-59

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone replacement for hypogonadism (related to opioids) Page(s): 110-111.

Decision rationale: The request for AndroGel 1%, (5g) gel packet (50mg/5g) #1 is not medically necessary. The California MTUS Guidelines state testosterone replacement therapy is recommended in limited circumstances for patients taking high dose long term opioids with documented low testosterone levels. Routine testing of testosterone levels and then taking opioids is not recommended, however, an endocrine evaluation and/or testosterone levels should be considered in men who are taking long term, high dose, or opioids or intrathecal opioids and who exhibit symptoms or signs of hypogonadism. There is a lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the request submitted failed to provide a treatment site. Therefore, the request is not medically necessary.

Lidoderm 5,#30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm and Topical Analgesics Page(s): 56-57 and 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL NSAIDS Page(s): 111-112.

Decision rationale: The request for Lidoderm 5%, #30 is not medically necessary. The California MTUS Guidelines recommend topical NSAIDs for osteoarthritis and tendonitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use, 4 to 12 weeks. The guidelines note Lidoderm is primarily

recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.