

Case Number:	CM14-0184540		
Date Assigned:	11/12/2014	Date of Injury:	09/19/1988
Decision Date:	12/15/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	11/05/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 55-year-old male who reported an injury of unspecified mechanism on 09/19/1988. On 09/15/2014, his diagnoses included failed back surgery syndrome, lumbar radiculitis, and lumbar degenerative disc disease. He had a history of falls, increased lower back pain, and instability and weakness to both legs. He was status post right hip fracture with an open reduction internal fixation. His medications included AndroGel 5%, Lidoderm patch 5%, OxyContin 20 mg, Valium 10 mg, Ambien CR 12.5 mg, and Methadone 10 mg. There was no rationale included in this worker's chart for the requested medications. A request for authorization dated 09/24/2014 was included.

IMR ISSUES, DECISIONS AND RATIONALES

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

AndroGel 5% #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Testosterone replacement for hypogonadism (related to opioids).

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

Decision rationale: The request for AndroGel 5% #60 is not medically necessary. The California MTUS Guidelines recommend testosterone replacement therapy for hypogonadism in limited

circumstances for patients taking high dose, long term opioids with documented low testosterone levels. Hypogonadism has been noted in patients receiving intrathecal opioids and long term high dose opioids. Routine testing of testosterone levels in men 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 oral opioids or intrathecal opioids and who exhibit symptoms or signs of hypogonadism, such as gynecomastia. This injured worker was taking 3 different opioid medications. It is unclear from the submitted documentation the length of time he had been taking these medications. There was no evidence of hypogonadism or gynecomastia in the submitted documents. The need for this medication was not clearly demonstrated with the submitted documentation. Additionally, the form of AndroGel, route of administration and frequency of administration were not included in the request. Therefore, this request for Androgel 5% #60 is not medically necessary.

Lidoderm patches 5% #60: Upheld

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): 111-113.

Decision rationale: The request for Lidoderm patches 5% #60 is not medically necessary. The California MTUS Guidelines refer to topical analgesics as largely experimental with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Lidocaine is recommended for localized peripheral pain after there has been evidence of failed trials of first line therapy including tricyclic or SNRI antidepressants and/or an antiepileptic medication such as gabapentin or Lyrica. The only form of FDA approved topical application of Lidocaine is the 5% transdermal patch for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. There was no evidence in the submitted documentation of failed trials of antidepressants or antiepileptic medications. There was no indication that this injured worker was suffering from postherpetic neuralgia. The request did not specify a body part or parts which were to have been treated or a frequency of application. Therefore, this request for Lidoderm patches 5% #60 is not medically necessary.

Valium 10mg #60: 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 request for Valium 10mg #60 is not medically necessary. The California MTUS Guidelines do not recommend benzodiazepines for long term use because long

term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant and muscle relaxant effects. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance develops within weeks or months. It was noted in the submitted documentation that this injured worker has been taking this medication for greater than 3 months, which exceeds the recommendations in the guidelines. Additionally, there was no frequency of administration included with the request. Therefore, this request for Valium 10mg #60 is not medically necessary.

Ambien CR 12.5mg #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), Non-benzodiazepine hypnotic.

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 (Ambien)

Decision rationale: The request for Ambien CR 12.5mg #30 is not medically necessary. Per the Official Disability Guidelines, Ambien is a short acting non benzodiazepine hypnotic, which is approved for short term treatment of insomnia, usually 2 to 6 weeks. While sleeping pills, so called minor tranquilizers, are commonly prescribed for 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 more than opioid pain relievers. There is also concern that they may increase pain and depression over the long term. Additionally, Ambien has been linked to a sharp increase in emergency room visits, so it should be used safely for only a short period of time. This worker has been taking Ambien for longer than 3 months, which exceeds the recommendations in the guidelines. Additionally, the request did not include frequency of administration. Therefore, this request for Ambien CR 12.5mg #30 is not medically necessary.