

<b>Case Number:</b>	CM14-0041536		
<b>Date Assigned:</b>	06/30/2014	<b>Date of Injury:</b>	08/27/1999
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	03/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2014

### 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 Management 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:

This is a patient with a date of injury of 8/27/99. A utilization review determination dated 3/27/14 recommends denial of Zolpidem, Lidoderm, Voltaren gel, and Prevacid. 3/5/14 medical report identifies no subjective or objective findings. Medications are noted to be Daypro, Lidoderm, Baclofen, Imitrex, and Ambien. 2/7/14 medical report identifies pain 7/10 with no adverse medication effects. Using Lidoderm with some relief. On exam, there is limited Range of Motion (ROM), left knee joint line tenderness, positive McMurray, and thigh atrophy. Recommendations include Prevacid, Zolpidem, Lidoderm, Voltaren gel, Cyclobenzaprine, left knee MRI, Ortho Eval, and Physical Therapy (PT).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Zolpidem 10mg.5 1 tab po qhs:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers Compensation, Online Edition. Chapter: Pain Ambien (zolpidem tartrate)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) Chronic Pain, Sleep Medication

**Decision rationale:** Regarding the request for Zolpidem (Ambien), California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there is no description of the patient's insomnia, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to Ambien treatment. Finally, there is no indication that Ambien is being used for short-term treatment as recommended by guidelines. In the absence of such documentation, the currently requested Zolpidem (Ambien) is not medically necessary.

**Lidoderm Patches #60 x 3 Refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

**Decision rationale:** Regarding the request for Lidoderm, CA MTUS states that Topical Lidocaine is "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica)." Within the documentation available for review, there is no indication of localized peripheral neuropathic pain and failure of first-line therapy. In light of the above issues, the requested Lidoderm is not medically necessary.

**Voltaren Gel 1 percent:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** Regarding the request for Voltaren gel, CA MTUS states that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Within the documentation available for review, it appears that the patient may have osteoarthritis of the knee, but there is no indication of efficacy as evidenced by quantifiable pain relief and/or functional improvement from use of the medication. Furthermore, there is no clear rationale for the long-term use of topical NSAIDs in addition to oral NSAIDs given that the CA MTUS supports only short-term use. In light of the above issues, the requested Voltaren gel is not medically necessary.

**Prevacid 30 mg 1 cap po daily:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton Pump Inhibitors (PPIs)

**Decision rationale:** Regarding the request for Lansoprazole (Prevacid), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested Lansoprazole is not medically necessary.