

<b>Case Number:</b>	CM14-0084475		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	07/17/2001
<b>Decision Date:</b>	11/14/2014	<b>UR Denial Date:</b>	05/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/06/2014

### 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 Emergency Medicine and is licensed to practice in New York. 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 65-year-old female who was injured on July 17, 2001. The patient continued to experience low back pain. Physical examination was notable for tightness and tenderness of the lumbar spine, tenderness on lumbar extension, and negative straight leg raise. Diagnoses included lumbar facet arthropathy, thoracic/lumbosacral neuritis/radiculitis, lumbago, and degeneration of lumbosacral intervertebral disc. Treatment included medications and radiofrequency rhizotomy. Requests for authorization for Lidoderm 5% # 60 with three refills and Ambien 10 mg #30 with 3 refills were submitted for consideration.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm 5 % #60 3 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain interventions and Guidelines Page(s): 112.

**Decision rationale:** Lidocaine is recommended for localized peripheral pain after the evidence of a trial for first-line therapy, such as an antidepressant or antiepileptic drug. It is only FDA approved for the treatment of post-herpetic neuralgia. The guidelines state that further research

is needed to recommend this treatment for chronic neuropathic pain. Criteria for use of Lidoderm patches: (a) Recommend for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. (b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). (c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. (d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale. (e) The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day). (f) ) A Trial of patch treatment is recommended for a short-term period (no more than four weeks). (g) It is generally recommended that no other medication changes be made during the trial period. (h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued. (i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued. In this case the diagnosis of neuropathic pain is not supported by the documentation in the medical record. In addition there is no documentation that the Lidoderm patches have been effective. The request should not be authorized.

**Ambien 10mg # 30 3 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: 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, Zolpidem

**Decision rationale:** Ambien is zolpidem, a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents 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 more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. Cognitive behavioral therapy (CBT) should be an important part of an insomnia treatment plan. A study of patients with persistent insomnia found that the addition of zolpidem immediate release to CBT was modestly beneficial during acute (first 6 weeks) therapy, but better long-term outcomes were achieved when zolpidem IR was discontinued and maintenance CBT continued. zolpidem is linked to a sharp increase in ED visits, so it should be used safely for only a short period of time. In this case the number of pills requested indicates long-term use of the medication. The duration of treatment surpasses the recommended short-term use of two to six weeks. The request should not be authorized.

