

<b>Case Number:</b>	CM14-0216565		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	05/07/2008
<b>Decision Date:</b>	04/03/2015	<b>UR Denial Date:</b>	12/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/26/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 52-year-old female who reported injury on 05/07/2008. The mechanism of injury was not provided. The injured worker had previously utilized Ambien, ibuprofen, Lidoderm patches, and Flector patches. Prior therapies included trigger point injections and physical therapy. The injured worker underwent a bilateral hemilaminotomy and decompression at L4-5 on 01/06/2012. The documentation of 10/08/2014 revealed the injured worker had persistent neck pain and low back pain as well as thoracic region pain. The injured worker was utilizing a lumbar spine brace which was noted to help. The injured worker had neck pain that was a "swollen feeling" associated with increased pain with activities. The injured worker had difficulty performing her routine activities due to persistent pain and intermittent swelling of the low back. The injured worker had an x-ray of the lumbar spine. The documentation of 10/16/2013 indicated the injured worker should have aggressive physical therapy, discontinue back brace, and had no indication for surgery. The injured worker underwent an arthroscopic rotator cuff repair, subacromial decompression and debridement of calcific mass of the right supraspinatus tendon on 06/25/2013. The objective finding revealed the injured worker had spasms in the cervical paraspinal muscles and stiffness in the cervical spine. There was tenderness to light touch in the cervical paraspinal and bilateral shoulder region musculature. There was tenderness in the left arm without obvious swelling. The diagnoses included neck pain. The treatment plan included Ambien 10 mg by mouth at bedtime as needed #20, ibuprofen 800 mg 1 by mouth twice a day #60, Lidoderm 5% patches 12 hours on and 12 hours off, and Flector patch 1.3% apply to skin twice a day #30, with 3 refills for all medications, x-rays of the

cervical spine to rule out gross abnormality, and 8 to 12 sessions of physical therapy for neck pain for home exercise teaching and modality trials. The subsequent documentation of 02/05/2015 revealed the injured worker wanted to pursue x-rays of her neck prior to physical therapy. Additionally, the injured worker indicated that generic Lidoderm patches did not help for pain. The request was made for additional 12 weeks for 6 to 8 sessions of physical therapy for neck pain and an x-ray of the cervical spine to rule out underlying gross abnormalities.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Ambien 10mg #20 with 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 and Mosby's Drug Consult.

**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, Zolpidem.

**Decision rationale:** The Official Disability Guidelines indicate Zolpidem (Ambien) is appropriate for the short-term treatment of insomnia, generally 7-10 days. The clinical documentation submitted for review indicated the medication was beneficial. However, there was a lack of documentation of exceptional factors to warrant no adherence to guideline recommendations. There was a lack of documentation indicating a necessity for 3 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Ambien 10 mg #20 with 3 refills is not medically necessary.

**Ibuprofen 800 mg #60 with 3 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDS are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and an objective decrease in pain. There was a lack of documentation indicating a necessity for 3 refills without re-evaluation. The request as submitted failed to

indicate the frequency for the requested medication. Given the above, the request for ibuprofen 800 mg #60 with 3 refills is not medically necessary.

**Lidoderm patch 5% 30 with 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 Lidoderm Page(s): 56, 57.

**Decision rationale:** The California Medical Treatment & Utilization Schedule guidelines indicate that topical lidocaine (Lidoderm) may be 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). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide the efficacy for the requested medication. There was a lack of documentation of a trial of first line therapy. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating a necessity for 3 refills without re-evaluation. Given the above, the request for Lidoderm patch 5% 30 with 3 refills is not medically necessary.

**Flector patch 1.3% #30 with 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 Topical Analgesics, Topical NSAIDS Page(s): 111.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines indicate that Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. The indications for the use of topical NSAIDs are osteoarthritis and tendinitis of the knee and other joints that can be treated topically. They are recommended for short term use of 4-12 weeks. There is little evidence indicating effectiveness for treatment of osteoarthritis of the spine, hip or shoulder. The clinical documentation submitted for review failed to provide documentation the injured worker had a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation indicating a necessity for 3 refills without re-evaluation. The request as submitted failed to indicate the frequency for the requested

medication and the body part to be treated. Given the above, the request for Flector patch 1.3% #30 with 3 refills is not medically necessary.

**X-ray, 2 views, cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate for most injured workers presenting with true neck or upper back problems, special studies are not needed unless there is a 3 to 4 week period of conservative care and observation that fails to improve symptoms. The criteria for ordering imaging studies include the emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery or the clarification of the anatomy prior to an invasive procedure. The clinical documentation submitted for review indicate the request for a cervical spine x-ray was to rule out an underlying gross abnormality. The prior conservative care specifically directed at the cervical spine was not provided. There was a lack of documentation of physiologic evidence of tissue insult. There was a lack of documentation indicating that the request was for a clarification of the anatomy prior to an invasive procedure. There was a lack of documentation of a failure to progress in a strengthening program intended to avoid surgery. Given the above, the request for x-ray 2 views cervical spine is not medically necessary.

**Physical therapy 8-12 sessions, unspecified and duration, neck:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend physical medicine treatment for myalgia and myositis for up to 10 visits. The clinical documentation submitted for review indicated the injured worker had undergone physical medicine. However, there was a lack of documentation of objective functional deficits and documentation of prior objective functional benefit. Given the above, the request for physical therapy 8 to 12 sessions unspecified and duration neck is not medically necessary.