

<b>Case Number:</b>	CM15-0100326		
<b>Date Assigned:</b>	06/08/2015	<b>Date of Injury:</b>	10/13/1999
<b>Decision Date:</b>	07/16/2015	<b>UR Denial Date:</b>	05/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

### 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 female, who sustained an industrial injury on 10/13/1999. Diagnoses include back pain, post laminectomy syndrome status post lumbar decompression, lumbar or thoracic radiculopathy, left L5 radicular pain and associated numbness, adjustment reaction with prolonged depressive reaction, depression reactive to injury and chronic pain currently stable and degenerative disc disease. Treatment to date has included surgical intervention, diagnostics, medications including Flexeril, Lidoderm 5% patch, Norco 10/325mg, Nabumetone and Ambien and aqua therapy. Per the Primary Treating Physician's Progress Report dated 5/07/2015, the injured worker reported left low back pain and buttock pain with radiation down the left lower extremity to the foot. Physical examination revealed diffuse tenderness to palpation of the lumbar spine with reduced range of motion. Straight leg raise was positive on the left. The plan of care included medications and authorization was requested for Norco, Ambien, Flexeril, and Lidoderm patch.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien CR 12.5mg, #15: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) - Zolpidem (Ambien).

**Decision rationale:** Ambien 12.5mg #15 is not medically necessary per the ODG guidelines. The MTUS Guidelines do not address insomnia or Ambien. The ODG states Zolpidem (Ambien) is approved for the short-term (usually two to six weeks) treatment of insomnia. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, 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. The documentation indicates that the patient has been on Ambien prior to this request. The ODG does not recommend this medication long term. The request for Ambien is not medically necessary.

**Flexeril 5mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42 and page 64.

**Decision rationale:** Flexeril 5mg, #60 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that Cyclobenzaprine is not recommended to be used for longer than 2-3 weeks. The documentation indicates that the patient has already been on Cyclobenzaprine. There is no evidence of functional improvement from prior use. There are no extenuating circumstances documented that would necessitate continuing this medication beyond the 2-3 week time frame. The request for Flexeril is not medically necessary.

**Lidoderm patch, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56.

**Decision rationale:** Lidoderm Patch,#60 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines The guidelines state that topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic 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. The documentation does not indicate failure of first line therapy for peripheral pain. The documentation does not indicate a diagnosis of post herpetic neuralgia. For these reasons the request for Lidoderm Patch is not medically necessary.