

<b>Case Number:</b>	CM15-0108931		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	06/26/2001
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 59 year old male who sustained an industrial injury on 6/26/01. The injured worker was diagnosed as having status post anterior cervical discectomy and fusion with ongoing neck and left arm pain. Currently, the injured worker was with complaints of neck pain with radiation to the left shoulder. Previous treatments included medication management. Previous diagnostic studies included a magnetic resonance imaging. The injured workers pain level was noted as 8/10 without medication and 4/10 with medication. Physical examination was notable for limited range of motion in the neck and pain with cervical compression in the left shoulder blade area. The plan of care was for medication prescriptions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm 5% patches #60:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine Patch) Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter Lidoderm.

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

**Decision rationale:** Per MTUS Guidelines, topical lidocaine is used primarily for neuropathic pain when trials of antidepressant and anticonvulsants have failed. Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritics. The injured worker is receiving significant subjective pain relief with the use of Lidoderm patches, therefore the request for Lidoderm 5% patches #60 is determined to be medically necessary.

**Trazodone 150mg #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, Mental Illness & Stress Chapter-Trazodone.

**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/Insomnia Treatment Section.

**Decision rationale:** Trazodone is not addressed by the MTUS Guidelines. Per the ODG, sedating antidepressants such as Trazodone have been used to treat insomnia; however, there is less evidence to support their use for insomnia. Trazodone may be an option for patients with coexisting depression. There is no current assessment of the continued need of Trazodone. The benefits for sleep and depression in this particular injured worker are not addressed. Additionally, there is no documentation that the provider has addressed non-pharmacologic methods for sleep disturbances, such as proper sleep hygiene. The request for Trazodone 150mg #30 is determined to be not medically necessary.

**Ambien 10mg #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 (Pain Chapter, Ambien); FDA (Ambien).

**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/Insomnia Section.

**Decision rationale:** The MTUS Guidelines do not address the use of Zolpidem. Per the Official Disability Guidelines, pharmacological agents should only be used for insomnia management after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically whereas secondary insomnia may

be treated with pharmacological and/or psychological measures. Zolpidem reduces sleep latency and is indicated for the short-term treatment (7-10 days) of insomnia with difficulty of sleep onset and/or sleep maintenance. Adults who use Zolpidem have a greater than 3-fold increased risk for early death. Due to adverse effects, FDA now requires lower doses for Zolpidem. The dose for women should be reduced from 10 mg to 5 mg for immediate release products and from 12.5 mg to 6.25 mg for extended release products. The medical records do not address the timeline of the insomnia or evaluation for the causes of the insomnia. The medical records do not indicate that non-pharmacological modalities such as cognitive behavioral therapy or addressing sleep hygiene practices prior to utilizing a pharmacological sleep aid. The request for Ambien 10mg #30 is determined to be not medically necessary.