

Case Number:	CM15-0188627		
Date Assigned:	09/30/2015	Date of Injury:	04/02/2008
Decision Date:	12/01/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	09/24/2015

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: Tennessee, Florida, Ohio
 Certification(s)/Specialty: Surgery, Surgical Critical Care

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 female who sustained an industrial injury on 4-2-08. The injured worker reported bilateral upper extremity pain. A review of the medical records indicates that the injured worker is undergoing treatments for carpal tunnel syndrome, ulnar neuropathy, lateral epicondylitis, medial epicondylitis and right shoulder pain. Medical records dated 9-8-15 indicate pain rated at 7 out of 10. Treatment has included Wellbutrin, Ambien, Lyrica, Clonazepam, Norco, Voltaren topical gel, Intermezzo, electromyography of bilateral upper extremities (8-1-12), and therapy. Objective findings dated 9-8-15 were notable for right shoulder with restricted range of motion and tenderness to palpation in the biceps groove and subdeltoid bursa. The treating physician indicates that the urine drug testing result (6-18-15) showed no aberration. The original utilization review (9-15-15) denied a request for Norco 10-325 milligrams quantity of 90, Ambien 12.5 milligrams quantity of 30, Intermezzo 1.75 milligrams quantity of 10, Lyrica 100 milligrams quantity of 90, Wellbutrin Sr 150 milligrams quantity of 90 and Lidocaine 5% (700 milligrams).

IMR ISSUES, DECISIONS AND RATIONALES

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

Intermezzo 1.75mg #10: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Zolpidem.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of this medication. Per the Official Disability Guidelines (ODG), "zolpidem is not recommended for long-term use." Intermezzo is sublingual release zolpidem. The clinical records submitted do support the fact that this patient has a remote history of insomnia. However, the records do not support the long-term use of this medication for that indication. Specifically, the patient's most recent clinical encounters do not document signs or symptoms of current insomnia, which justifies long-term medication use. Therefore, based on the submitted medical documentation, the request for intermezzo is not medically necessary.

Lidocaine 5% (700mg): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Lidoderm (lidocaine patch).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this medication for this patient. Per the California MTUS Chronic Pain guidelines, topical analgesics are recommended as an option and are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The FDA has designated topical lidocaine, in the formulation of a dermal patch, for neuropathic pain. No other commercially approved topical formulation of lidocaine is indicated for neuropathic pain. The clinical information submitted for review fails to provide evidence of a failure to respond to antidepressants or anticonvulsants prior to the request for an initiation of a topical analgesic. Hence, the request for Terocin is not appropriate or indicated by MTUS guidelines. Therefore, based on the submitted medical documentation, the request for lidocaine 5% is not medically necessary.