

<b>Case Number:</b>	CM15-0041072		
<b>Date Assigned:</b>	03/11/2015	<b>Date of Injury:</b>	09/02/1998
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	02/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/04/2015

### 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: 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 54-year-old female, who sustained an industrial injury on 9/02/1998. She was diagnosed as having post laminectomy lumbar spine, post laminectomy cervical, impingement syndrome and cervical spondylosis with myelopathy. Treatment to date has included diagnostics, activity modification, injections, consultations, medications, surgical interventions: lower back (2005), neck (2009) and left shoulder (2012). She underwent an anterior cervical fusion at C5-6 (undated). Per the Primary Treating Physician's Progress Report dated 2/02/2015, the injured worker reported mid back pain, low back pain, bilateral shoulder pain and neck pain. Pain is described as constant and severe with profound limitations. Associated symptoms included weakness and numbness to both legs and radiation to the neck and shoulders. The plan of care included medications, lumbosacral support and follow up care. Authorization was requested for Ambien CR , Terocin and Oxycontin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien CR tablet 12.5mg #30:** 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 Pain chapter, Insomnia treatment.

**Decision rationale:** The patient presents with pain and weakness in her neck, lower back and upper/lower extremities. The request is for AMBIEN CR TABLET 12.5MG #30. Per 02/02/15 progress report, the patient is currently taking Percocet, Diazepam, Xanax, Sertralinem, Norco, Nexium and Vitamin D. The patient remains off work. ODG guidelines, Drug Formulary, have the following regarding Ambien for insomnia: "Zolpidem --Ambien --generic available--, Ambien CR-- is indicated for the short-term treatment of insomnia with difficulty of sleep onset -7-10 days--. Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien CR to be effective for up to 24 weeks in adults." In this case, none of the reports discuss specifically this medication except "continue Ambien CR." The patient has been suffering from insomnia for which this medication may be indicated. However, there is no indication that this medication is to be used for a short-term. The ODG guidelines support only short-term use of this medication, in most situations no more than 7-10 days. The request IS NOT medically necessary.

**Xanax 0.5mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** The patient presents with pain and weakness in her neck, lower back and upper/lower extremities. The request is for XANAX 0.5MG #120. Per 02/02/15 progress report, the patient is currently taking Percocet, Diazepam, Xanax, Sertralinem, Norco, Nexium and Vitamin D. The patient remains off work. For benzodiazepines, the MTUS Guidelines page 24 states, "Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependency." The review of the reports indicates that the patient has been utilizing Xanax prior to 02/02/15. The treater does not document how long this medication is being used with what effectiveness. The MTUS Guidelines recommends maximum of 4 weeks due to "unproven efficacy and risk of dependence." The requested Xanax IS NOT medically necessary.

**Terocin #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical lidocaine Page(s): 56-57, 112. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Lidoderm.

**Decision rationale:** The patient presents with pain and weakness in her neck, lower back and upper/lower extremities. The request is for TEROGIN #30. Per 02/02/15 progress report, the patient is currently taking Percocet, Diazepam, Xanax, Sertraline, Norco, Nexium and Vitamin D. The patient remains off work. MTUS guidelines page 57 states, "topical lidocaine 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--." MTUS Page 112 also states, "Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain." When reading ODG guidelines, it specifies that lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. In this case, this patient presents with neck/low back pain with radicular symptoms, a diffuse neuropathic condition. There is no documentation of localized, peripheral neuropathic pain for which this product is indicated. Therefore, the request IS NOT medically necessary.