

Case Number:	CM15-0055962		
Date Assigned:	04/01/2015	Date of Injury:	01/01/1999
Decision Date:	05/04/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	03/24/2015

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: 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 48 year old female, who sustained an industrial injury on 1/1/99. She reported pain in the lower back and neck. The injured worker was diagnosed as having cervical degenerative disc disease, lumbar post laminectomy syndrome and insomnia. Treatment to date has included a lumbar MRI, lumbar fusion, an EMG/NCV study and pain medications. As of the PR2 dated 1/22/15, the injured worker reports 8/10 pain in the lumbar spine with right lower extremity pain and weakness. The treating physician indicated the injured worker had difficulty with rising from a sitting position and moved with stiffness. The treating physician requested to continue an Avid IF2 stimulator, Zolpidem Tartrate 5mg and Lidoderm 5% patch.

IMR ISSUES, DECISIONS AND RATIONALES

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

Durable Medical Equipment Rental - Avid IF2 Stimulator (interferential) - 2 channel programmed - (retrospective for date of service 9-12-14) Bilateral Arm, Back, Neck, Psyche, Both Hips: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The patient presents with pain and weakness in her neck, lower back and upper/lower extremities. The request is for Retro Durable Medical Equipment Rental Avid IF2 stimulator (interferential) 2 channel programmed for Bilateral Arm, Back, Neck, Psyche and Both Hips. DOS 09/12/14. Per 09/05/14 progress report, the patient had s/p spinal stimulator removal and L5-S1 lumbar fusion and cervical surgery in 2010. The patient has had cervical ESI on 08/04/14. The patient has had EMG/NCV studies and the results are not provided. Work status is unknown. MTUS guidelines page 118-120 states "Interferential Current Stimulation (ICS) Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or - Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.) If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits." In this case, the utilization review letter on 02/23/15 indicates that "a 2-month rental of an interferential unit had been authorized on 01/15/14." The treater does not explain why interferential unit is being requested. Review of progress reports does not show documentation of operative condition, history of substance abuse, ineffective medication, nor unresponsiveness to conservative measures. None of the reports discuss the outcome from the previous use. MTUS requires 30-day trial of the unit showing pain and functional benefit before a home unit is allowed. The request is not medically necessary.

Zolpidem Tartrate 5 mg Qty 30 (retrospective for date of service 1/24/12, 5/24/12 and 3/21/12): 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.

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

Decision rationale: The patient presents with pain and weakness in her neck, lower back and upper/ lower extremities. The request is for Retrospective Zolpidem Tartrate 5 mg #30, DOS 01/24/12, 03/21/12 and 05/24/12. Work status is unknown. 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, the utilization review letter on 02/23/15 indicates that the treater wanted to begin tapering off Ambien per 02/22/12 progress report. 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.

Topical Lidoderm 5% (retrospective for date of service 8-16-12, 7-5-12, 5-23-12, 5-1-12, 3-26-12, 2-20-12): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine, Topical Analgesic 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 Retrospective Lidoderm 5% Patch DOS 02/20/12, 03/26/12, 05/01/12, 05/23/12, 07/05/12 and 08/16/12. The treater provides reports from 01/22/15 to 07/24/14. Work status is unknown. 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.)" 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 documented for pain and function. In this case, it is not clear whether or not the patient has had localized pain that is consistent with a neuropathic etiology in 2012. The utilization review letter on 02/23/15 indicates that the patient has been utilizing Lidoderm patch prior to 02/22/12. There is no documentation how these patches are used, how often, and with what efficacy in terms of pain reduction and functional improvement. MTUS page 60 requires recording of pain and function when medications are used for chronic pain. The request is not medically necessary.