

<b>Case Number:</b>	CM14-0128558		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	08/11/2004
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	07/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas and Ohio. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 61 year old male who reported a date of injury of 08/11/2004. The mechanism of injury was not indicated. The injured worker had diagnoses of low back pain, L4 and L5 degenerative joint disease and facet degenerative joint disease. Prior treatments included physical therapy. The injured worker had an x-ray on 02/24/2014 with official findings indicating the injured worker had multilevel degenerative disc disease of the lumbar spine with displace narrowing and osteophyte formation and facet arthropathy. Surgeries were not indicated within the medical records provided. The injured worker had complaints of low back pain. The clinical note dated 09/02/2014 noted the injured worker's lumbar spine had tenderness to palpation over the L4 and L5 areas, paraspinal spasms were noted on the right side, positive trigger points were observed, a positive straight leg raise was noted, and the injured worker had an abnormal gait. The injured worker's range of motion was noted to be reduced by 50 percent, the sensory and motor exams were normal, and deep tendon reflexes were normal. Medications included tramadol, acetaminophen, Lunesta and Lidoderm patches. The treatment plan included Lunesta and Lidoderm patches. The rationale was not indicated within the medical records provided. The request for authorization form was dated 07/23/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm Patch 5%, qty 30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Patch (lidocaine patch).

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

**Decision rationale:** The injured worker had complaints of low back pain. The California MTUS guidelines indicate lidocaine patches should not be used as a first-line treatment and are only FDA approved for post-herpetic neuralgia. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy with tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. There is a lack of documentation indicating the injured worker has failed first-line of treatment with tri-cyclic or SNRI anti-depressants or an anti-epilepsy drug such as gabapentin or Lyrica. There is a lack of documentation demonstrating the injured worker has post-herpetic neuralgia or neuropathic pain. Additionally, the request does not indicate the frequency at which the medication is prescribed and the site at which it is to be applied in order to determine the necessity of the medication. As such, the request is not medically necessary.

**Lunesta 3mg, qty 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, Eszopicolone (Lunesta); Official Disability Guidelines, Mental Illness and Stress Chapter, Eszopicolone (Lunesta); Official Disability Guidelines, Pain Chapter, Insomnia Treatment

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

**Decision rationale:** The injured worker had complaints of low back pain. The Official Disability Guidelines recommend treatment for insomnia be based on etiology. Medications should only be used after careful evaluation of the causes of potential sleep disturbances, the specific components of insomnia should be addressed, sleep onset, sleep maintenance, sleep quality and next day functioning. Treatment for insomnia is recommended for a short duration of 4 weeks or less, as there is lack of research based evidence supporting long term usage. There is a lack of documentation indicating the injured worker had complaints of sleep disturbances or difficulty in staying asleep, as well as the duration of any reported insomnia symptoms. Furthermore, the guidelines recommend a short course of treatment for 4 weeks or less. The injured worker is noted to have been utilizing Lunesta since at least 07/23/2013. The continued use of Lunesta would exceed the guideline recommendation for a short course of treatment. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. As such, the request is not medically necessary.

