

Case Number:	CM14-0172892		
Date Assigned:	10/24/2014	Date of Injury:	11/28/2001
Decision Date:	12/03/2014	UR Denial Date:	10/10/2014
Priority:	Standard	Application Received:	10/20/2014

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 has a subspecialty in Interventional spine and is licensed to practice in California. 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 patient is a 55-year-old male with a date of injury of 11/28/2001. The listed diagnoses per [REDACTED] are: 1.Low back pain.2.Hypogonadism male.3.Depression.4.Insomnia secondary to chronic pain.5.Erectile dysfunction.6.Anxiety.7.Back pain.8.Fecal incontinence.9.Localized hyperhidrosis.According to progress report 09/23/2014, the patient presents with chronic low back pain. He has had a lumbar fusion in 2006 and has not been able to return to work since that. The patient complains that he is having trouble getting his medication and it is causing him tremendous amount of stress. The patient's current medication regimen includes Viagra, metoprolol succinate, Diovan, lansoprazole, Opana 10 mg, Nuvigil 150 mg, diazepam 10 mg, trazodone 150 mg, hydrocodone/APAP, Questran 4 mg, zolpidem 10 mg, alprazolam 1 mg, gabapentin 100 mg, and AndroGel 1% topical application. Physical examination was not performed on this date. The treater is requesting a refill of AndroGel 1% #6 and zolpidem 10 mg. Utilization review denied the request on 10/10/2014. Treatment reports from 04/08/2014 through 09/23/2014 were reviewed.

IMR ISSUES, DECISIONS AND RATIONALES

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

AndroGel 1 percent #6: 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 (ODG) pain chapter has the following regarding testosterone FDA regarding Androgel
<http://www.fda.gov/downloads/Drugs/DrugSafety/UCM255313.pdf>

Decision rationale: This patient presents with chronic low back pain. The treater is requesting a refill of AndroGel 1% #6 2 daily with 5 refills. The MTUS, ACOEM, and ODG Guidelines do not discuss AndroGel. Therefore, an alternate resource was consulted. The FDA has the following regarding AndroGel. "AndroGel 1.62% is a prescription medication that contains testosterone. 1.62% is used to treat adult males who have low or no testosterone. It is recommended the healthcare providers test patient's blood before they start and while they are taking AndroGel 1.6%." ODG Guidelines under its pain chapter has the following regarding testosterone, "Recommended in limited circumstances for patients taking high-dose long-term opioids with documented low testosterone levels." In this case, the treater does not provide the patient's testosterone levels, no evidence of gynecomastia on exam, and there are no reports of blood testing prior to initiating this medication. Although the patient has a diagnosis of hypogonadism, there is no testosterone levels noted as recommended by the FDA and ODG Guidelines therefore request is not medically necessary.

Zolpidem 10mg: 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

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, zolpidem (Ambien)

Decision rationale: This patient presents with chronic low back pain. The treater is requesting a refill of zolpidem 10 mg 1 tablet to be taken at bedtime. The MTUS and ACOEM Guidelines do not address zolpidem. The ODG Guidelines under its pain chapter states that zolpidem (Ambien) is indicated for short-term treatment of insomnia with difficulty of sleep onset 7 to 10 days. The medical records indicate that the patient has been prescribed zolpidem since at least 04/08/2014. In this case, ODG Guidelines do not recommend long-term use of this medication therefore request is not medically necessary.