

Case Number:	CM14-0184376		
Date Assigned:	11/12/2014	Date of Injury:	12/05/2009
Decision Date:	12/18/2014	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	11/04/2014

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 Internal Medicine and is licensed to practice in New York. 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 claimant is 48 year old male who sustained an industrial injury on 12/05/2009. The mechanism of injury was not provided for review. His diagnoses include cervical discopathy, bilateral upper extremity overuse tendinopathy, lumbar sprain, anxiety, depression, gastrointestinal disturbance, left carpal tunnel syndrome and status post right carpal tunnel release. He continues to complain of neck and upper arm pain with numbness. On physical exam there is decreased range of cervical motion without any defined motor or sensory changes on neurologic exam. Treatment has included medical therapy with narcotics and topical compounded medications. The treating provider has requested Alprazolam ER 1mg one tab po qhs #30, Zolpidem 10mg one po qhs prn #30, and Lidocaine 6%/Gabapentin 10%/Ketoprofen 10% cream, 120gm, apply 1-2 grams to affected area 3-4 times daily.

IMR ISSUES, DECISIONS AND RATIONALES

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

Alprazolam ER 1mg one tab po qhs #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines.

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

Decision rationale: Alprazolam (Xanax) is a short-acting benzodiazepine drug having anxiolytic, sedative, and hypnotic properties. The medication is used in conjunction with antidepressants for the treatment of depression with anxiety, and panic attacks. Per California MTUS Guidelines, benzodiazepines are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Most guidelines limit use to four weeks. The medical documentation indicates the claimant has continued symptoms of depression with anxiety and sleep issues related to the work injuries. The claimant is not maintained on any anti-depressant medication. Medical necessity for the requested medication has not been established. The requested treatment is not medically necessary.

Zolpidem 10mg one po qhs prn #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/Treatment in Workers Compensation

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

Decision rationale: Zolpidem (Ambien) is a short-acting nonbenzodiazepine hypnotic indicated for the short-term treatment (two to six weeks) for managing insomnia. Long-term use is not recommended as there are associated risks of impaired function and memory with use more than opioids, as well as Ambien may be habit forming. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Lidocaine 6%/Gabapentin 10%/Ketoprofen 10% cream, 120gm, apply 1-2 grams to affected area 3-4 times daily: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Per California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, γ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, topical Gabapentin is not FDA approved for topical use. Medical

necessity for the requested item has not been established. The requested treatment is not medically necessary.