

Case Number:	CM14-0210223		
Date Assigned:	12/23/2014	Date of Injury:	08/08/1996
Decision Date:	02/19/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	12/15/2014

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. 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 & Rehabn

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 63-year-old male with a date of injury of 08/08/1996. According to progress report dated 10/28/2014, the patient presents with right-sided lumbar pain and lower extremity pain. Physical examination revealed marked tenderness at the right SI joint. There is full painless range of motion of the thoracic and lumbar spine and normal stability and strength noted. Examination of the left lower extremity revealed muscle strength of the major groups is 5/5 and there is normal tone. Examination of the right lower extremity revealed strength of major groups is 4/5 and normal tone. The patient has antalgic gait favoring the right and requires a cane for assistance in ambulation. There is a positive FABERE's, Stork sign and SI joint compression test on the right. The listed diagnoses are: 1. Chronic pain. 2. Sacroiliitis. 3. Degenerative lumbosacral intervertebral disk. 4. Lumbar sprain/strain. The patient is temporarily totally disabled x6 weeks. Treatment plan is for refill of medications including Norco, Ambien, Lidoderm patches, and Prilosec. It was noted that risks, benefits, and alternatives to current medications were discussed including direction to read and understand packages health warnings. The utilization review denied the request on 11/17/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm Patch 5% #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

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

Decision rationale: This patient presents with chronic low back pain and lower extremity pain. The current request is for Lidoderm patches 5% #60. The 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)." The MTUS guidelines state that Lidoderm patches may be recommended for neuropathic pain when trials of antidepressants and anti-convulsants have failed. In this case, the patient does not present with localized peripheral pain but suffers from chronic low back pain. In addition, there is no evidence of failed trials of antidepressants and anti-convulsants as recommended by MTUS. This patient does not meet the criteria for lidocaine patches. This request is not medically necessary.

Norco 7.5-325 mg tablets #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medication for chronic pain; Criteria for Use of Opioids Page(s): 60-61, 76-78, 88-89.

Decision rationale: This patient presents with chronic right-sided lumbar pain and lower extremity pain. The current request is for Norco 7.5/325 mg tablets #60. For Chronic opiate use, the MTUS Guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, recommendation for further use of Norco cannot be made as all the 4As are not addressed as required by MTUS for opiate management. The treating patient has failed to provide any pain scale to denote decrease in pain and there are no examples of ADLs which demonstrate medication efficacy nor there are any discussions regarding functional improvement or change in work status to document significant functional improvement. There are no opiate management issues discussed such as CURES report, pain contracts, etc. Per progress report dated 09/16/2014, a urine drug screen is to be attained. In this case, the treating physician has failed to provide minimum requirements of documentation that are outlined in MTUS for continued opiate use. The requested Norco is not medically necessary.

Ambien CR 12.5ng TBCR #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Zolpidem (Ambien)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter Regarding Zolpidem (Ambien); Insomnia Treatment

Decision rationale: This patient presents with chronic right-sided low back pain and lower extremity pain. The current request is for Ambien CR 12.5ng TBCR #30. The MTUS and ACOEM Guidelines do not address Ambien (zolpidem); however, the ODG Guidelines under the mental illness and stress chapter regarding zolpidem (Ambien) states, "zolpidem (Ambien generic available, Ambien CR) is indicated for short-term treatment of insomnia with difficulty of sleep onset (7-10 days)." In this case, the current request is for #30 Ambien 1 and review of the medical file indicates the patient has been taking this medication since 8/18/14. The patient has been prescribed Ambien for chronic insomnia, and the ODG only supports short-term usage. The requested Ambien is not medically necessary.

Prilosec 20mg CPDR #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Omeprazole Page(s): 68-69.

Decision rationale: This patient presents with chronic right-sided low back pain and lower extremity pain. The current request is for Prilosec 20 mg CPDR #30. The MTUS Guidelines pages 68 and 69 states that Omeprazole is recommended with precaution for patients at risk for gastrointestinal events: (1) Age is greater than 65, (2) History of peptic ulcer disease and GI bleeding or perforation, (3) Concurrent use of ASA or corticosteroid and/or anticoagulant, (4) High dose/multiple NSAID. Review of the medical reports provides no GI assessments and no discussion regarding gastrointestinal issues. In addition, the patient's medication regimen does not include a NSAID to consider the use of Prilosec. The requested Prilosec 20 mg is not medically necessary.

Keto 10%, GABA 6%, Lido 10% 60g: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

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

Decision rationale: This patient presents with chronic right-sided low back pain and lower extremity pain. The current request is for Keto 10%, Gaba 6%, lido 10% 60 g. The MTUS Guidelines p 111 has the following regarding topical creams, "topical analgesics are largely

experimental and used with few randomized control trials to determine efficacy or safety." MTUS further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." Under Ketoprofen, MTUS states, "This agent is not currently FDA approved for a topical application." Furthermore, Gabapentin is not recommended in any topical formulation and lidocaine is approved in a patch form only; therefore, the entire compound topical cream is rendered invalid. This topical compound medication is not medically necessary.