

<b>Case Number:</b>	CM15-0017540		
<b>Date Assigned:</b>	02/05/2015	<b>Date of Injury:</b>	12/17/2003
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	01/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/29/2015

### 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, Arizona

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 50-year-old female who reported an injury on 12/17/2003. The mechanism of injury was not provided. There was a Request for Authorization submitted for review dated 01/16/2015. The diagnoses included cervical degenerative disc disease, lumbar degenerative disc disease, and status post surgical and myofascial pain. The documentation of 01/16/2015 revealed the injured worker was in the office for prescription refills. The documentation indicated the medications were necessary to cure or relieve the injured worker's symptoms.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm 5% patch Qty:60.00:** Upheld

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

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

**Decision rationale:** The California Medical Treatment & Utilization Schedule guidelines indicate that topical lidocaine (Lidoderm) 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). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide a rationale. There is a lack of documentation of objective functional benefit and an objective decrease in pain and documentation the injured worker had a trial and failure of first line therapy. The request as submitted failed to indicate the frequency and the body part to be treated. Given the above, the request for Lidoderm 5% patch QTY: 60 is not medically necessary.

**Zolpidem 10mg Qty:30.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Treatment in Workers' Comp on the Web ([www.odgtreatment.com](http://www.odgtreatment.com)). Work Loss data Institute ([www.worklossdata.com](http://www.worklossdata.com)):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) Pain, Zolpidem

**Decision rationale:** The Official Disability Guidelines indicate that zolpidem is recommended for the short term treatment of insomnia. The clinical documentation submitted for review indicated the injured worker had utilized the medication. The duration of use was not established. There was a lack of documentation indicating the efficacy for the requested medication. The frequency was not provided per the submitted request. Given the above, the request for zolpidem 10 mg QTY: 30 is not medically necessary.

**Omeprazole 20mg Qty: 60.00:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend that injured workers be assessed for intermediate or high risk for gastrointestinal events and if they are found to be at risk, proton pump inhibitors should be utilized. Injured workers with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. The clinical documentation submitted for review indicated the injured worker had utilized the medication. There was a lack of documentation of objective functional benefit and there was a lack of documentation indicating the injured worker was at intermediate or high risk for gastrointestinal events. The request as submitted failed to indicate the frequency for the

requested medication. Given the above, the request for omeprazole 20 mg QTY: 60 is not medically necessary.

**Flexeril 7.5mg Qty: 60.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain. Their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review failed to provide documentation of the duration of use. It was noted the medication was a refill. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for Flexeril 7.5 mg #60 is not medically necessary.