

Case Number:	CM15-0128315		
Date Assigned:	07/14/2015	Date of Injury:	09/18/2001
Decision Date:	08/17/2015	UR Denial Date:	06/12/2015
Priority:	Standard	Application Received:	07/02/2015

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, Hawaii

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 56 year old female who sustained a work related injury September 18, 2001. Past history included failed back spinal surgery. According to a primary treating physician's progress report dated June 1, 2015, the injured worker presented with complaints of low back pain, rated 7-8 out of 10, with radiation down the bilateral legs. Her medication is tolerated well and helps 80% of the time. Handwritten notes and checklists are difficult to decipher. She is waiting to have a pump battery replaced. An update dated March 5, 2015, finds a refill interval of 62 days with a low reservoir alarm date of May 6, 2015. Objective findings included decrease in range of motion of the lumbar spine and increased pain with straight leg raise at 60 degrees. Range of motion measurements documented as; flexion 60 degrees, extension 10 degrees, right and left lateral 20 degrees. Diagnoses are lumbar sacral radiculitis; lumbar degenerative disc disease. Treatment plan included a checklist for weight loss and diet, refill medications, home exercise program, and ice and non-steroidal anti-inflammatory drugs (NSAID's). At issue, is the request for authorization for Lidoderm patch and Ambien.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patch 5% #60, apply two QD: Upheld

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

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

Decision rationale: The patient presents with pain affecting the low back with radiation to the bilateral legs. The current request is for Lidoderm patch 5% #60, apply two QD. The treating physician report dated 6/1/15 (53B) provides no rationale for the current request. The MTUS guidelines state Lidoderm is "Not recommended until after a trial of a first-line therapy, according to the criteria below. Lidoderm is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. Topical lidocaine may be recommended for localized neuropathic 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." In this case there is no evidence in the documents provided that the patient underwent any first-line therapy. The current request is not medically necessary.

Ambien tab 10mg #30, 1 PO Q HS: 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 online version, 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 Chapter, Zolpidem (Ambien).

Decision rationale: The patient presents with pain affecting the low back with radiation to the bilateral legs. The current request is for Ambien tab 10mg #30, 1 PO Q HS. The treating physician report dated 6/1/15 (53B) provides no rationale for the current request. The MTUS and ACOEM Guidelines do not address Ambien; however, the ODG Guidelines states that zolpidem (Ambien) is indicated for short-term treatment of insomnia with difficulty of sleep onset 7 to 10 days. In this case, the use of this medication exceeds the 7-10 days recommended by the ODG as the medical records provided indicate the patient has been prescribed Ambien since at least 1/5/15 (14B). A short course of 7 to 10 days may be indicated for insomnia, however, the treating physician is requesting 10mg #30. The ODG Guidelines do not recommend long-term use of this medication. The current request is not medically necessary.