

Case Number:	CM15-0061177		
Date Assigned:	04/07/2015	Date of Injury:	04/20/1997
Decision Date:	05/29/2015	UR Denial Date:	03/13/2015
Priority:	Standard	Application Received:	03/31/2015

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
 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 54-year-old male who sustained an industrial injury on 04/20/1997. Diagnoses include lumbago, displacement of lumbar disc without myelopathy, degenerative lumbar/lumbosacral intervertebral disc. Treatment to date has included diagnostic studies, medications, and physical therapy. A physician progress note dated 03/04/2015 documents the injured worker is status post lumbar fusion in December of 2013 but still has bladder incontinence issues and right worse than left lower extremity pain and spasm. The injured worker ambulates with a stiff non-antalgic gait and transfers from sit to stand with some stiffness and guarding. He has limited range of motion of the back on all directions and bends knees to reach the floor. Treatment requested is for Ambien 10 mg #30, Lyrica 150 mg #90, Voltaren gel 100 g #5, and Xanax 0.25 mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lyrica 150 mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-22.

Decision rationale: The California MTUS Guidelines recommend anti-epilepsy drugs for neuropathic pain. In this case, the injured worker has continuously utilized the above medication since at least 09/2014. There is no documentation of objective functional improvement. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Voltaren gel 100 g #5: Upheld

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

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

Decision rationale: The California MTUS Guidelines state the only FDA approved topical NSAID is Voltaren gel 1%, which is indicated for the relief of osteoarthritis pain. In this case, the injured worker maintains a diagnosis of degeneration of lumbar or lumbosacral intervertebral disc. However, the California MTUS Guidelines state Voltaren gel 1% has not been evaluated for treatment of the spine. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Xanax 0.25 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: Benzodiazepines are not recommended for long-term use, because long term efficacy is unproven, and there is a risk of dependence. In this case, the injured worker does not maintain a diagnosis of anxiety disorder. Additionally, the injured worker has continuously utilized the above medication since 09/2014. There is no mention of functional improvement. The guidelines would not support long-term use of this medication. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Ambien 10 mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG; MedScape 2009; PDR 2009.

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 Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines recommend insomnia treatment based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker has continuously utilized the above medication since 09/2014. There is no documentation of a failure to respond to non-pharmacologic treatment. The injured worker does not maintain a diagnosis of insomnia disorder. There is also no frequency listed in the request. As such, the request is not medically necessary.