

Case Number:	CM15-0069805		
Date Assigned:	04/17/2015	Date of Injury:	05/21/2005
Decision Date:	06/09/2015	UR Denial Date:	03/27/2015
Priority:	Standard	Application Received:	04/13/2015

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: New York

Certification(s)/Specialty: Anesthesiology

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 70 year old male who sustained an industrial injury on 5/21/05. He has reported initial complaints of being struck by a truck at work with injury to the lumbar spine. The diagnoses have included chronic low back pain, radicular syndrome of lower limb and lumbar post laminectomy syndrome. Treatment to date has included medications, activity modifications, lumbar surgery, and physical therapy. The diagnostic testing that was performed included X-ray of the lumbar spine. The current medications included Ambien, Gabapentin, and Lidoderm patch. Currently, as per the physician progress note dated 3/9/15, the injured worker complains of continued back pain and lung problems. It was noted that the physician would like to get more data to look into the cause of his pain. The physician also noted that there have been denials for services and medications for the injured worker. Physical exam revealed blood pressure of 113/71, pulse 89 and pain was rated 7/10 on pain scale. There were no other physical or objective findings noted. The diagnostics were not noted in the records. Work status was permanent and stationary and he was not working at the time of the exam. The physician requested treatments included Ambien 10mg #120.00, One Lumbar spine Magnetic Resonance Imaging (MRI), Epidural Steroid Injection (unspecified), Lumbar spine transmitter, Gabapentin 600mg QTY: 480.00 and Lidoderm 5% patches QTY: 120.00.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #120.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain (Chronic), 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) Insomnia treatment.

Decision rationale: Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia and is rarely recommended for long-term use. It can be habit-forming, and may impair function and memory more than opioid analgesics, and may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Guidelines do not support the use of Ambien on an indefinite or chronic basis. In this case, there is no documentation provided indicating medical necessity for Ambien. The requested medication is not medically necessary.

One Lumbar spine MRI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304, 309.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MRI of the lumbar spine Page(s): 304.

Decision rationale: According to California MTUS Guidelines, MRI of the lumbar spine is recommended to evaluate for evidence of cauda equina, tumor, infection, or fracture when plain films are negative and neurologic abnormalities are present on physical exam. In this case, there is no indication for an MRI of the lumbar spine. There are no subjective complaints of increased back pain, radiculopathy, bowel or bladder incontinence, and there are no new neurologic findings on physical exam. Therefore, there is no specific indication for an MRI of the lumbar spine. Medical necessity for the requested MRI has not been established. The requested imaging study is not medically necessary.

Epidural Steroid Injection (unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESIs Page(s): 46.

Decision rationale: Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in a dermatomal distribution with corroborative findings of radiculopathy). ESIs can offer short-term pain relief and use should be in conjunction with other rehab efforts. The purpose of ESIs is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. According to the CA MTUS guidelines, radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing. The patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case, there are no reported neurological findings or complaints of pain in a dermatomal pattern consistent with radiculopathy. In addition, there no MRI findings presented that reveal nerve compression. Medical necessity for the requested ESI has not been established. The requested ESI is not medically necessary.

Lumbar spine transmitter: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: It is unclear as to what the provider is actually requesting for this patient. IF a lumbar spine transmitter is referring to a spinal cord stimulator, the following rationale is below. According to the ODG, a spinal cord stimulator (SCS) is recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated. There is some evidence supporting the use of spinal cord stimulation for failed back surgery syndrome and other selected chronic pain conditions. In recent years it has been met with widespread acceptance and recognition by the medical community. The enhanced design of electrodes, leads, and receivers/stimulators has substantially decreased the incidence of re-operations for device failure. In addition, the introduction of the percutaneous electrode implantation has enabled trial stimulation, which is now commonly recognized as an indispensable step in assessing whether the treatment is appropriate for individual patients. However, there is no specific documentation indicating the need for a spinal cord stimulator in this case. Medical necessity for a SCS has not been established. The SCS is not medically necessary.

Gabapentin 600mg QTY: 480.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin); Anti-epileptic drugs(AEDs) Page(s): 18-19, 49, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 17-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) AEDs.

Decision rationale: Gabapentin (Neurontin) is an anti-epilepsy drug which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The records document that the patient has reported radiculopathy related to his chronic low back condition, without evidence of neuropathic pain. There is no documentation of objective findings consistent with current neuropathic pain to necessitate the use of Gabapentin. In addition, there is no documentation of benefit from the previous use of Gabapentin. Medical necessity for Gabapentin has not been established. The requested medication is not medically necessary.

Lidoderm 5% patches QTY: 120.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 56-57.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics, such as Lidoderm patches, 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, for example, NSAIDs, opioids, or antidepressants. Lidoderm is the brand name for a lidocaine patch. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants, or an AED, such as gabapentin or Lyrica). Lidoderm patches are not a first-line treatment and are 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. In addition, this medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. In this case, medical necessity of the requested item has not been established. The requested Lidoderm patches are not medically necessary.