

Case Number:	CM13-0008012		
Date Assigned:	03/19/2014	Date of Injury:	06/28/2011
Decision Date:	08/07/2014	UR Denial Date:	07/26/2013
Priority:	Standard	Application Received:	08/09/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, Pain Medicine and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 had a work related injury on 06/28/11. There was no documentation of mechanism of injury. The injured worker has been seen and treated for trigeminal nerve dysfunction, trigeminal neuralgia, reflex sympathetic dystrophy upper extremities, psychogenic pain, common migraine, brain conditions, atypical face pain, and headaches. He is currently being treated with Percocet 5/325mg one tablet every eight hours as needed. Lidoderm 5% patch. Desipramine 10mg tablets. Lyrica 50mg tablets. Intermezzo 3.5mg at bedtime. Most recent clinical note dated 07/08/13 physical examination reported the patient was well developed, well nourished, and in no cardiorespiratory distress. He was alert and oriented times three. The patient ambulated to the examination room without assistance. He was able to set comfortably without difficulty or evidence of pain. Non-antalgic gait. In reviewing the clinical documentation submitted, there was no visual analogue scale (VAS) pain scale with and without medication. No clinical documentation of functional improvement. He had urine drug screen which was consistent with medications prescribed. Prior utilization review 07/26/13 modified Percocet, Desiprimine, and Lyrica. Current request was for prescription for Percocet 5/325mg every eight hours #60. Prescription for Lidoderm 5% patch (700mg) every 12 hours #30. Prescription for Desipramine 10mg one to two tablets at night #60 one prescription of Lyrica 50mg twice daily #90. One prescription for Intermezzo 3.5mg at bedtime #15.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION OF PERCOCET 5/325MG Q8H #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIATE'S Page(s): 74-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter, opioid's.

Decision rationale: The request for 1 prescription of Percocet 5/325 every 8 hours #60 is not medically necessary. The clinical documentation submitted for review and current evidence based guidelines do not support the request for Percodan. There is no documentation of visual analogue pain scale (VAS) with and without medications, and no documentation of functional improvement. As such medical necessity has not been established. However, these medications cannot be abruptly discontinued due to withdrawal symptoms, and medications should only be changed by the prescribing physician.

1 PRESCRIPTION OF LIDODERM 5% PATCH (700MG) Q12H #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Lidoderm® (lidocaine patch).

Decision rationale: The request for 1 prescription of Lidoderm 5% patch (700mg) every 12 hours #30 is not medically necessary. The current evidence based guidelines do not support the request for Lidoderm Patch. This is not a first-line treatment and is only Food and Drug Administration (FDA) approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Therefore, medical necessity has not been established.

1 PRESCRIPTION OF DESIPRAMINE 10MG 1-2 TABS QHS #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS FOR CHRONIC PAIN Page(s): 13-14.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIDEPRESSANTS FOR CHRONIC PAIN Page(s): 13-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Antidepressants for chronic pain.

Decision rationale: The request for 1 prescription for Desipramine 10mg 1-2 tabs at night # 60 is not medically necessary. The clinical documentation submitted for review as well as current evidence based guidelines do not support the request for Desipramine. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated.

There is no clinical documentation submitted that confirms the injured worker had been on tricyclics prior to desipramine. As such medical necessity has not been established.

1 PRESCRIPTION OF LYRICA 50MG BID #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SPECIFIC ANTI-EPILEPSY DRUGS Page(s): 20.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16-22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Anti-epilepsy drugs (AEDs) for pain.

Decision rationale: The request for 1 prescription of Lyrica 50mg twice daily # 90 is not medically necessary. The clinical documentation submitted for review and current evidence based guidelines do not support the request for Lyrica. There is no documentation of visual analogue scale (VAS) pain scale with and without medications, and no documentation of functional improvement. Therefore medical necessity has not been established.

1 PRESCRIPTION OF INTERMEZZO 3.5MG SL QHS #15: 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) Pain Chapter.

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 request for 1 prescription of Intermezzo 3.5mg under the tongue at night #15 is not medically necessary. The current evidence based guidelines do not support the request for Intermezzo (Zolpidem). Zolpidem is a prescription of short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. The clinical documentation submitted, reveals that the injured worker has been on the medication greater than six weeks. As such, medical necessity has not been established.