

Case Number:	CM13-0035342		
Date Assigned:	12/13/2013	Date of Injury:	09/17/2001
Decision Date:	04/14/2014	UR Denial Date:	10/02/2013
Priority:	Standard	Application Received:	10/17/2013

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 Family Medicine and is licensed to practice in Arizona. 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:

Patient is a 47 year old female with a date of injury on 9/17/2001. Patient has been treated for ongoing symptoms related to her neck and low back. Diagnoses include myofascial pain, chronic pain syndrome, and cervical radiculopathy. Subjective complaints are of persistent neck and back pain, of which medication has been helpful to some extent. Physical exam show cervical and bilateral trapezius tenderness with decreased range of motion. There is lumbar tenderness and decreased range of motion. Medications include feldene, zantac, sonata, ultram (Tramadol), and Lidoderm patches. Submitted documentation does not identify a history of GI disturbance, a description of insomnia, or specific pain relief or functional improvement with ultram or Lidoderm.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION OF ZANTAC 150MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK,.

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

Decision rationale: According to CA MTUS guidelines, a proton-pump inhibitor (PPI) or H2 blocker can be added to NSAID therapy if the patient is at an intermediate to high risk for adverse GI events. Guidelines identify the following as risk factors for GI events: age >65, history of peptic ulcer, GI bleeding or perforation, use of acetylsalicylic acid (ASA), corticosteroids, anticoagulant use, or high dose NSAIDs. There is no documentation identified that would stratify this patient in an intermediate or high risk GI category. CA MTUS specifically states that treatment of dyspepsia secondary to NSAID therapy should include stopping the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. Since the patient has no history of peptic ulcers, GI bleeding, or documentation of dyspepsia secondary to NSAID use, the requested prescription for Zantac is not medically necessary.

1 PRESCRIPTION OF SONATA 10MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation NON-MTUS, OFFICIAL DISABILITY GUIDELINES (ODG), PAIN(CHRONIC).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG PAIN, INSOMNIA TREATMENT

Decision rationale: The ODG recommends Sonata for short-term use (7-10 days) is indicated, and a controlled trial showing effectiveness for up to 5 weeks. For this patient, the records do not identify the extent or type of insomnia that this patient suffers from. Furthermore, guidelines only recommend this medication for short term use. Therefore, the medical necessity of Sonata is not certified.

1 PRESCRIPTION OF ULTRAM 50MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRAMADOL Page(s): 93.

Decision rationale: CA MTUS recognizes Tramadol as a synthetic opioid that affects the central nervous system. Therefore, the patient in question has been on chronic opioid therapy. CA Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear Final Determination Letter for IMR Case Number [REDACTED] evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. No documentation is presence of MTUS opioid compliance guidelines, including risk assessment, attempt at weaning, updated urine drug screen, and ongoing efficacy of medication. For this patient, there is no demonstrated improvement in pain or function from long-term use. For these reasons, the medical necessity for Tramadol is not certified.

1 PRESCRIPTION OF LIDODERM PATCHES #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PAIN-LIDODERM(LIDOCAINE PATCH),.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LIDODERM Page(s): 56.

Decision rationale: CA MTUS recommends Lidoderm as a second line treatment for localized peripheral pain after there has been evidence of first line therapy treatment failure. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. The submitted documentation does not provide evidence for post-herpetic neuralgia or for localized peripheral pain. Furthermore, Lidoderm is only recommended after a trial of a first-line medication such as a tricyclic drug. There is no trial of a first line medication evident in the medical records. Therefore, the medical necessity of Lidoderm patches is not certified.