

Case Number:	CM13-0048551		
Date Assigned:	12/27/2013	Date of Injury:	05/15/1996
Decision Date:	05/21/2014	UR Denial Date:	10/24/2013
Priority:	Standard	Application Received:	11/06/2013

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 Neurology, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in California. 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 patient is a 55-year-old man who sustained a work-related injury on May 15, 1996. Subsequently, he developed chronic low back, neck, and ankle pain. The patient's surgical history includes knee surgery in 2010; gastric bypass, carpal tunnel surgery, shoulder replacement, and knee replacement in 2011; and back surgery in both 2009 and 2011. Postoperative complications include the development of complex regional pain syndrome, which was treated with sympathetic blocks and stimulation. He was also diagnosed with protrusion in the lumbar spine, depression, and a tear in his ankle. As of May 2, 2013, his physical examination demonstrated difficulty with ambulation. There was mild weakness in the lower extremities. Range of motion of the right knee was intact. There were positive Fabre's maneuvers to the left with pain over the facets from L3 to S1. The patient was treated with AndroGel, Docusate, Fanapt, Fentanyl patch, Gabapentin, Lidoderm patch, Lorazepam, Lunesta, Naftin, Omeprazole, Percocet, Pristiq, Tegaderm dressings, and Voltaren gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

60 PRISTIQ 50MG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.rxlist.com/pristiq-drug/htm.

Decision rationale: Pristiq is a structurally novel SNRI for the treatment of major depressive disorder. There is no documentation of major depressive disorder in the medical records provided for review. Therefore, the prescription of Pristiq is not medically necessary.

60 FANAPT 4MG: 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 www.rxlist.com/fanapt-drug.htm.

Decision rationale: Fanapt is an atypical antipsychotic generally prescribed for the treatment of schizophrenia by regulating dopamine and serotonin to improve mood, thinking, and behavior. There is no documentation of psychiatric disorders or a psychiatric evaluation in the medical records provided for review. Therefore, the prescription of Fanapt is not medically necessary.

30 LIDODERM 5% PATCHES: Upheld

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

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

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. According to the patient's file, there is no documentation of failure of first line therapies. Without such documentation, topical analgesics cannot be recommended. Therefore the prescription for Lidoderm patches is not medically necessary.

60 TOPIRAMATE 25MG: 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 www.rxlist.com/topamax-drug/side-effects-interactions.htm.

Decision rationale: Topamax (topiramate) tablets and sprinkle capsules are indicated as initial monotherapy in patients two years of age and older for partial onset or primary generalized tonic-clonic seizures. It is also indicated for headache prevention, and for neuropathic pain. There is no documentation of any of these conditions in the medical records provided for review. Therefore, the prescription of topiramate is not medically necessary.

60 TAMSULOSIN 0.4MG: 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 www.rxlist.com/flomax-drug/indications-dosage.htm.

Decision rationale: Flomax (tamsulosin hydrochloride) capsules are indicated for the treatment of the signs and symptoms of benign prostatic hyperplasia. There is no clinical evidence in the medical records provided for review that the patient has developed this condition. Therefore, the request for tamsulosin is not medically necessary.

ANDROGEL 1%, 150ML: 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 www.rxlist.com/androgel-drug/indications-dosage.htm.

Decision rationale: Androgel 1% is an androgen indicated for replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone. There is no documentation in the medical records provided for review that the patient has developed hypogonadism. Therefore, the prescription of Androgel is not medically necessary.

NAFTIN 2%, 45ML: 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 www.rxlist.com/naftin-gel-drug/indications-dosage.htm.

Decision rationale: Naftin gel 1% is indicated for the topical treatment of tinea pedis (athlete's foot), tinea cruris (jock itch), and tinea corporis (ringworm of the body) caused by *Trichophyton rubrum*, *Trichophyton mentagrophytes*, *Trichophyton tonsurans*, and *Epidermophyton floccosum*, all types of fungus. There is no clinical evidence in the medical records provided for

review that the patient has developed a fungal infection. Therefore, the prescription of Naftin is not medically necessary.

VOLTAREN GEL 1%, 200G: Upheld

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

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

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no clear evidence that the patient has developed neuropathic pain. There is no documentation of failure or intolerance of NSAIDs, or oral first line medications for the treatment of pain. Therefore, the request for Voltaren gel is not medically necessary.

50 TEGADERM DRESSINGS, 4" X 4 ¼": Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75-81.

Decision rationale: According to the MTUS guidelines, Tegaderm is an adhesive wound dressing used to allow better adhesion. However, there is no documentation of wound assessment in the medical records provided for review. Without such information, Tegaderm patches cannot be recommended, and the request must be considered not medically necessary.

90 GABAPENTIN 600MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49.

Decision rationale: According to MTUS guidelines, Gabapentin is an anti-epilepsy drug (AED) that has been shown to be effective for the treatment of diabetic painful neuropathy and postherpetic neuralgia. It has been considered as a first-line treatment for neuropathic pain. There is no clear evidence that the patient's pain is predominantly neuropathic. In addition, there is no

clear evidence that Gabapentin is effective in the treatment for chronic neck and back pain. There are no controlled studies supporting the use of Gabapentin for the treatment of chronic back pain. Therefore, the request for Gabapentin is not medically necessary

30 CELEBREX 200MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 27-30.

Decision rationale: According to the MTUS guidelines, Celebrex is indicated for back pain after failure or contraindication of NSAIDs. There is no clear documentation that NSAIDs are contraindicated for this patient, or that they have been tried and failed. Therefore, the prescription of Celebrex is not medically necessary.

0 SKELAXIN 800MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

Decision rationale: According to MTUS guidelines, Skelaxin is a non-sedating muscle relaxant, and is recommended with caution as a second line option for the short term treatment of acute exacerbations of chronic spasm and pain. Efficacy appears to diminish over time, and prolonged use may cause dependence. The patient in this case does not have clear recent evidence of spasm and the prolonged use of Skelaxin is not justified. As such, the request for Skelaxin is not medically necessary.