

Case Number:	CM13-0062727		
Date Assigned:	06/09/2014	Date of Injury:	02/03/1999
Decision Date:	12/31/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/09/2013

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, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 50-year-old female who had a work injury dated 2/3/99. The diagnoses include CRPS lower extremities; spinal cord stimulator in place; situational depression; severe dental decay. Under consideration are requests for the medications Cymbalta, Wellbutrin, Nexium, Provigil, Lidoderm 5%; Naprosyn; Klonipin; Flexeril; Glucosamine, Voltaren Gel; Soma, Dilaudid, and Maxalt. A 10/7/13 document states that the patient has increased cervical pain. She will receive trigger point injections and a Dilaudid refill. On exam she is alert and has moderate to severe pain with increased sitting. The evaluation of her lumbar and sacral spine revealed myofascitis consistent with altered mechanics with pain down to her Piriformis muscle and hips bilaterally. The examination of her lower extremities shows tactile allodynia, hyperpathia, hyperhydrosis, and discoloration pallor with coldness to the extremities bilaterally. There is pain with manipulation of the extremities bilaterally. Peripheral pulses are adequate bilaterally. The treatment plan included a refill of the above medications under consideration. A 9/9/13 document states that that the patient has increased cervical pain. The patient was given 10 trigger point injections in her cervical area and the medications under consideration were refilled. There is 8/7/13 document that states that the patient had severe increase in depression symptoms. The patient received a refill of her meds that were under consideration. A review of the documentation indicates that the patient had cervical trigger point injections on 6/19/13; 9/9/13; 10/7/13; 11/18/13. There are inconsistent urine toxicology reports on 5/5/13 for Opana, which was prescribed which was also negative on confirmatory testing.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta 60mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 60.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that Cymbalta is FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia and used off-label for neuropathic pain and radiculopathy. There is no high quality evidence is reported to support the use of duloxetine for lumbar radiculopathy. More studies are needed to determine the efficacy of duloxetine for other types of neuropathic pain. The documentation does not indicate that the patient has had functional improvement from prior Cymbalta use. There is no evidence this medication has improved her pain or depression levels. The request for Cymbalta is not medically necessary.

Wellbutrin 400mg: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that Wellbutrin is a second-generation non-tricyclic antidepressant (a noradrenaline and dopamine reuptake inhibitor) has been shown to be effective in relieving neuropathic pain of different etiologies in a small trial (41 patients). The documentation does not indicate evidence of functional improvement or improvement in pain levels from prior Wellbutrin therefore this request is not medically necessary.

Nexium 20mg, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that the patient is at risk for gastrointestinal events if they meet the following criteria (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The guidelines

also state that a proton pump inhibitor can be considered if the patient has NSAID induced dyspepsia. The documentation does not indicate that the patient meets the criteria for a proton pump inhibitor therefore the request for Nexium is not medically necessary.

Provigil 200mg, #120: 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 Official Disability Guidelines (ODG) Modafinil (Provigil®)

Decision rationale: The California MTUS Guidelines do not discuss Provigil. The Official Disability Guidelines state that this medication is not recommended solely to counteract sedation effects of narcotics until after first considering reducing excessive narcotic prescribing. Provigil is indicated to improve wakefulness in adult patients with excessive sleepiness associated with narcolepsy, obstructive sleep apnea, and shift work sleep disorder. Patients should have a complete evaluation with a diagnosis made in accordance with the International Classification of Sleep Disorders or DSM diagnostic classification. The documentation does not indicate that the patient has a proven sleep disorder. The request for Provigil is not medically necessary.

Lidoderm 5%, #60: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is 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. The documentation does not indicate failure of first line therapy for peripheral pain. The documentation does not indicate a diagnosis of post herpetic neuralgia. The documentation indicate no evidence of functional improvement from prior Lidoderm use. The request for Lidoderm 5% #60 is not medically necessary.

Maxalt 10mg, #60: 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 Official Disability Guidelines (ODG) Pain- Rizatriptan (Maxalt®)

Decision rationale: The California MTUS Guidelines do not address Maxalt. The Official Disability Guidelines indicate that Maxalt is recommended for migraine sufferers. The documentation is not clear on the benefits of prior Maxalt use for this patient for migraines. The request for Maxalt is not medically necessary.

Naprosyn 550mg, #60: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines indicate that anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. The documentation indicates that the patient has been on Naprosyn without evidence of improved pain or function. The request for continued Naprosyn is not medically necessary.

Klonopin .5mg, #90: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant.. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. The documentation indicates that the patient has been on Klonopin longer than the recommended 4 week period and there is no evidence of functional improvement. The documentation does not indicate extenuating circumstances which would necessitate going against guideline recommendations. Klonopin is not medically necessary.

Flexeril 10mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42, 64.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that Cyclobenzaprine (Flexeril) is not recommended to be used for longer than 2-3 weeks. The documentation indicates that the patient has already been on Flexeril. There is no evidence of functional improvement from prior use. There are no extenuating circumstances documented that would necessitate continuing this medication beyond the 2-3 week time frame. The request does not indicate a quantity. The request for Flexeril is not medically necessary.

Glucosamine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that glucosamine is recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. The request does not indicate a quantity. The documentation does not indicate objective findings of knee osteoarthritis therefore, Glucosamine is not medically necessary.

Voltaren Gel 1%, #300: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that topical NSAIDs are indicated for short term use (4-12 weeks) for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment and are recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine; hip or shoulder. The documentation does not indicate functional improvement from prior use of Voltaren Gel therefore the request for Voltaren Gel 1% is not medically necessary.

Soma 350mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain: Carisoprodol (Soma®)

Decision rationale: The Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines both recommend against using Soma and state that it is not for long-term use. Both guidelines state that abuse has been noted for sedative and relaxant effects. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. The documentation indicates that the patient has been on Soma long term, which is against guideline recommendations. There is no evidence of functional improvement from this medication. There are no extenuating circumstances that would warrant the continuation of this medication. The request for Soma 350mg is not medically necessary.

Dilaudid 2mg, #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78-80.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that a pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Guidelines do not support ongoing opioid use without improvement in function or pain. The documentation submitted reveals that the patient has been on long term opioids without significant functional improvement therefore the request for Dilaudid is not medically necessary.