

Case Number:	CM14-0000869		
Date Assigned:	01/22/2014	Date of Injury:	03/21/2003
Decision Date:	06/02/2014	UR Denial Date:	12/23/2013
Priority:	Standard	Application Received:	01/02/2014

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 Pain Management 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:

This is a female patient with a date of injury of March 21, 2003. A utilization review determination dated December 23, 2013 recommends non-certification of Lyrica, Ultram, Dilaudid, Baclofen, Voltaren Gel, Tizanidine, Lidoderm patches, and Lidoderm cream (all for 12 months). A letter dated April 19, 2013 identifies subjective complaints including pain in the wrists, forearms, and hands right greater than left. The note identifies increased swallowing [sic] pain and discoloration particularly in the hands and forearms with a change in temperature. Typical of complex partial pain syndrome or RDS. In order to maintain her activities of daily living, she needs a combination of Lyrica, Ultram, Dilaudid, Baclofen, Voltaren gel, Tizanidine, Lidocaine gel cream, and Lidoderm patches. The objective examination findings identify trigger points involving her hands, forearms, shoulders, trapezius, and splenius capitis. A note dated July 13, 2013 has similar subjective complaints, objective findings, and recommends the same medication. No diagnoses have been listed on any progress reports.

IMR ISSUES, DECISIONS AND RATIONALES

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

LYRICA 150MG 2 TID FOR 12 MONTHS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 16-22.

Decision rationale: Regarding request for Lyrica, Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS), and no documentation of specific objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. In the absence of such documentation, the currently requested Lyrica is not medically necessary.

ULTRAM 50MG 2Q4H FOR 12 MONTHS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

Decision rationale: Regarding the request for Ultram, California Pain Medical Treatment Guidelines state that Ultram is a short acting opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the Ultram is improving the patient's function (in terms of specific objective functional improvement) or pain (in terms of reduced NRS, or percent reduction in pain), no documentation regarding side effects, and no discussion regarding aberrant use. In the absence of such documentation, the currently requested Ultram is not medically necessary.

DILAUDID 4MG Q4H FOR 12 MONTHS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

Decision rationale: Regarding the request for Dilaudid (Hydromorphone), California Pain Medical Treatment Guidelines state that Dilaudid is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use.

Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the Dilaudid is improving the patient's function or pain (in terms of percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. In the absence of such documentation, the currently requested Dilaudid (Hydromorphone) is not medically necessary.

BACLOFEN 10MG 1Q6H FOR 12 MONTHS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: Regarding the request for Baclofen, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that Baclofen specifically is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the Baclofen. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Baclofen is not medically necessary.

VOLTAREN GEL 1% APPLY AS NEEDED FOR 12 MONTHS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113.

Decision rationale: Regarding the request for Voltaren gel, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there's no indication that the patient has obtained any specific analgesic effect (in terms of percent reduction in pain, or reduced NRS) or specific objective functional improvement from the use of Voltaren gel. Additionally, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the Voltaren is for short term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested Voltaren gel is not medically necessary.

TIZANIDINE 4MG 2-4 QHS FOR 12 MONTHS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: Regarding the request for Tizanidine, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that Tizanidine specifically has been shown to be beneficial in the treatment of myofascial pain and as an adjunct to treat fibromyalgia. Guidelines recommend LFT monitoring at baseline, 1, 3, and 6 months. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the Tizanidine. Additionally, it does not appear that there has been appropriate liver function testing, as recommended by guidelines. In the absence of such documentation, the currently requested Tizanidine is not medically necessary.

LIDODERM PATCHES 5% AS NEEDED FOR 12 MONTHS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Lidoderm.

Decision rationale: Regarding request for topical lidoderm, Chronic Pain Medical Treatment Guidelines recommend the use of topical Lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Additionally, there is no documentation of analgesic effect or specific objective functional improvement as a result of the currently prescribed Lidoderm. Finally, there is no documentation of localized peripheral pain (supported by a diagnosis and physical examination findings) as recommended by guidelines. As such, the currently requested Lidoderm is not medically necessary.

LIDODERM CREAM 5% AS NEEDED FOR 12 MONTHS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Page(s): 112-113.

Decision rationale: Regarding request for Lidocaine cream, Chronic Pain Medical Treatment Guidelines recommend the use of topical Lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Guidelines go on to state that no commercially approved topical formulations of Lidocaine cream, lotion, or gel is indicated for neuropathic pain. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Furthermore, guidelines do not support the use of topical Lidocaine preparations which are not in patch form. As such, the currently requested Lidocaine cream is not medically necessary.