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| Case Number: | CM14-0002131 | | |
| Date Assigned: | 01/24/2014 | Date of Injury: | 08/22/2003 |
| Decision Date: | 07/18/2014 | UR Denial Date: | 12/20/2013 |
| Priority: | Standard | Application Received: | 01/07/2014 |

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 & Rehabilitation 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 injured worker is a 64-year-old male who reported an injury on August 22, 2003. The mechanism of injury was not provided within the medical records. The clinical note dated March 26, 2014 indicated the injured worker reported severe pain in the low back that radiated across his hips and he reported numbness. The injured worker rated his pain at 5/10 and reported it increased to a 10/10 when the pain was most severe. The injured worker reported pain in the thoracic area whenever he hunched over and cervical pain with sudden movements rated at 3-4/10. The injured worker reported numbness and tingling in both feet. He experienced spasms when he sensed instability and movement at L3-4 and he reported groin pain. He was able to do things for 5 minutes at a time such as sitting, walking, and preparing sandwiches. The injured worker had stiffness in his neck related to arm and shoulder pain. He said that he forgot about this pain because of his pain medicine. He had sleep disturbance, and only slept 4 to 5 hours a night. He had some relief from Lidoderm patches. The injured worker reported reduced social functioning and ongoing anxiety and depression. The injured worker's pain was constantly between moderate to severe in intensity, mostly severe. The injured worker's prior treatments have included diagnostic imaging, surgery, and medication management. The provider submitted a request for Percocet, Lyrica, Valium, Celebrex, Lidoderm and Butrans patches. The injured worker's medication regimen included Percocet, Lyrica, Valium, Relafen, and Lidoderm patches.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE (1) PRESCRIPTION OF PERCOCET 10/325MG (#120): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-going Management Page(s): 78.

Decision rationale: The request for Percocet 10/325mg (#120) is not medically necessary. The Chronic Pain Medical Treatment Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of significant evidence of evaluation of risk for aberrant drug use behaviors and side effects. Furthermore, the request does not indicate the frequency for the medications. Therefore, based on the documentation provided, the request is not medically necessary.

ONE (1) PRESCRIPTION OF LYRICA 75MG (#90 WITH 3 REFILLS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PREGABALIN (LYRICA).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pregabalin (Lyrica) Page(s): 99.

Decision rationale: The request for Lyrica 75mg (#90 with 3 refills) is not medically necessary. The Chronic Pain Medical Treatment Guidelines state Lyrica has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has FDA approval for both indications, and is considered first-line treatment for both. Lyrica was also approved to treat fibromyalgia. The guidelines also recommend Lyrica for neuropathic pain. A good response to the use of anti-epileptic drugs (AEDs) has been defined as a 50% reduction in pain and a moderate response as a 30% reduction. The injured worker has been on Lyrica since at least December 2013. There is a lack of functional improvement and efficacy. There is no evidence in the documentation provided of quantified pain relief with associated reduction in medication use. Therefore, the request is not medically necessary.

ONE (1) PRESCRIPTION OF VALIUM 5MG (#90 WITH 3 REFILLS): Upheld

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

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

Decision rationale: The request for Valium 5mg (#90 with 3 refills) is not medically necessary. The Chronic Pain Medical Treatment Guidelines state 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. Tolerance to hypnotic effects develops rapidly. The guidelines

do not recommend benzodiazepines for long-term use. Most guidelines limit the use to 4 weeks. The injured worker has been prescribed Valium since at least December 16, 2013. This exceeds the guideline's recommendations of 4 weeks. In addition, there was a lack of functional improvement. The injured worker continued with severe symptoms. Therefore, the request is not medically necessary.

ONE (1) PRESCRIPTION OF CELEBREX 200MG (#30 WITH 3 REFILLS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, SPECIFIC DRUG LIST & ADVERSE EFFECTS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, specific drug list and adverse effects, Selective COX-2 NSAIDS Page(s): 70.

Decision rationale: The request for Celebrex 200mg (#30 with 3 refills) is not medically necessary. The Chronic Pain Medical Treatment Guidelines state Celebrex is used for the relief of othe signs and and symptoms of osteoarthritis, rheumatoid arthritis, and ankylosing spondylitis. The documentation submitted did not indicate the injured worker had findings that would support he was at risk for osteoarthritis, rheumatoid arthritis or spondylitis. In addition, despite long-term use of Celebrex, the injured worker did not have functional improvement. The injured worker continued with significant symptoms. Therefore, the request is not medically necessary.

ONE (1) PRESCRIPTION OF LIDODERM PATCHES 5% (#30 WITH 3 REFILLS): Upheld

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

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

Decision rationale: The request for Lidoderm Patches 5% (#30 with 3 refills) is not medically necessary. The Chronic Pain Medical Treatment Guidelines states topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. The Lidoderm patch is not recommended as a first-line treatment. In addition, it is recommended in managing chronic neuropathic pain disorders such as diabetic neuropathy. The documentation submitted did not indicate the injured worker had findings that he was at risk for diabetic neuropathy. Moreover, there was no indication the injured worker had a trial of tricyclics or antidepressants or anti-epileptic drugs and failed them as a first-line treatment. Therefore, the request is not medically necessary.

ONE (1) PRESCRIPTION FOR BUTRANS PATCHES 20MCG (#4 WITH 3 REFILLS): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 26.

Decision rationale: The request for Butrans Patches 20mcg (#4 with 3 refills) is not medically necessary. The Chronic Pain Medical Treatment Guidelines state Butrans is recommended for treatment of opiate addiction. Also recommended as an option for chronic pain, especially after detoxification in patients who have a history of opiate addiction. In recent years, buprenorphine has been introduced in most European countries as a transdermal formulation (patch) for the treatment of chronic pain. Topical lidocaine in the formulation of a dermal patch is the only patch that is recommended where no other dermal patch formulations are generally indicated as local anesthetics and antipruritics, whether creams, lotions, or gels are indicated for neuropathic pain. Therefore, the request is not medically necessary.