

<b>Case Number:</b>	CM14-0016296		
<b>Date Assigned:</b>	04/11/2014	<b>Date of Injury:</b>	08/19/2011
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	02/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2014

### 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 Family Practice 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 58 year-old male who was injured at work on 8/19/2011. The injury was primarily to the right hip and right buttocks. He is requesting review of denial for the following ongoing medications: Vicodin, Amitriptyline, Lunestra, and Lidoderm Patch. Medical records for review include the Primary Treating Physician's Progress reports. These indicate that the patient continues to have ongoing problems with pain to the lower back and right hip. A physical examination is documented at each visit and is typically notable for decreased range of motion of the lumbar spine and tenderness and spasm to palpation of the thoracic and lumbar areas. Diagnoses include the following: Chronic Lumbar Back Pain; Multilevel Degenerative Disc Disease; Mild to Moderate Neuroforaminal Narrowing at L4-L5 and L5-S1; Chronic, Lower Extremity Radicular Symptoms; and Chronic Right Trochanteric Bursitis. The treatment plan includes: Vicodin, Amitriptyline, and Lidoderm. The patient underwent a Panel Qualified Medical Examination on 7/24/2013. This evaluation included a review of his medical records and an examination. The diagnostic impression included the following: Status Post Low Back Injury Without Radicular Involvement, Chronic Discogenic Low Back Pain Without Active Radiculopathy, and Multilevel Degenerative Disc Disease.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**VICODIN 5MG QTY: 120.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , 91

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS Page(s): 74-97.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines provide the criteria for the ongoing use of opioids. These criteria state that actions should include the following: 1. Prescriptions from a single practitioner and all prescriptions from a single pharmacy. 2. There should be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. 3. There should be evidence of "the 4 A's for Ongoing Monitoring." These domains include: analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. 4. There should be evidence of drug screening to assess for doctor-shopping or drug diversion. 5. There should be evidence of continuing review of the overall situation with regard to nonopioid means of pain control (Page 78). The medical records indicate that the patient is also receiving opioids from his [REDACTED] as well. There is no documentation to indicate that there has been an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. There is no documentation of efforts to assess for doctor-shopping or drug diversion. There is no documentation for continuing review of the overall situation with regard to nonopioid means of pain control. For all of these reasons, the ongoing use of Vicodin in this patient is not considered as medically necessary.

**AMITRIPTYLINE 25MG QTY: 240.00:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ANTIDEPRESSANTS FOR CHRONIC PAIN, 13-16

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 13-16.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines provide the criteria for the use of amitriptyline. These criteria state that amitriptyline is "recommended." Specifically, that "amitriptyline is a tricyclic antidepressant." This class of drugs "are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated." The MTUS/Chronic Pain Medical Treatment Guidelines additionally state that antidepressants, such as amitriptyline, are "recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain." It is unclear what rationale was used during the Utilization Review process to determine that amitriptyline was a non certified item. Nevertheless, there is sufficient documentation in the medical records to support the use of amitriptyline in this case as a first-line agent for the type of chronic pain experienced by this patient. There is no evidence that amitriptyline is poorly tolerated or contraindicated. The dose of amitriptyline of 25 mg at night is a commonly used regimen. The request for Amitriptyline 25mg Qty: 240.00 is medically necessary.

**LUNESTRA 2MG QTY: 120.00: 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 OFFICIAL DISABILITY GUIDELINES (ODG), CHRONIC PAIN/INSOMNIA TREATMENT

**Decision rationale:** The Official Disability Guidelines state the criteria for the use of pharmacologic agents in the treatment of insomnia. These guidelines indicate that "pharmacologic agents should only be used after careful evaluation of the potential causes of the sleep disturbance. Failure of the sleep disturbance to resolve in 7-10 days may indicate a psychiatric and/or medical illness. There is no evidence in the medical records to indicate that the patient has undergone an assessment for the underlying cause of his insomnia. Given the absence of assessment for the potential causes of sleep disturbance, the use of Lunesta is not considered as medically necessary.

**LIDODERM PATCH 5% (QUANTITY UNSPECIFIED) QTY: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , 56-57

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 111-113.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of topical analgesics for pain. These agents are described as "largely experimental in use with few randomized controlled trials to determine efficacy or safety." They are primarily recommended "for neuropathic pain when trials of antidepressants and anticonvulsants have failed." Lidocaine is recommended "for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressant or an AED such as Gabapentin or Lyrica). The records available for review are insufficient in determining whether the physician is using Lidoderm for the treatment of neuropathic pain. The distribution of the patient's pain as documented in the record is not localized and peripheral. Further, if it is assumed that the patient is being treated for neuropathic pain, there is insufficient documentation for adequate trials of antidepressants and anticonvulsants. Based on the insufficient documentation, Lidocaine is not considered as being medically necessary in this patient.