MAXIMUS Federal Services

Case Number:	CM14-0126198		
Date Assigned:	08/13/2014	Date of Injury:	06/13/2002
Decision Date:	10/01/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	08/08/2014

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 Sports 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 61-year old female with an injury reportedly related to a fall at work on 06/13/2002. She is status post C5-6 cervical fusion on 3/16/2007. She continues treatment for chronic neck and low back pain. The patient completed an orthopedic AME re-evaluation on 2/27/2014. She continued care with [redacted] for neck and back pain and [redacted] for pain management, who prescribed Suboxone. Documented medications for this visit included Suboxone, Wellbutrin, Lidoderm patches, and Advil. She is P&S as of 1/26/2008. The patient reportedly places Lidoderm patches locally on her back and buttock. Diagnoses listed included: cervical spine, status post C5-6 discectomy and fusion with C6 radiculopathy; Lumbar spine mild DDD (Degenerative Disc Disease) with sciatica; Multiple joint OA/tendinitis including elbows, knees, and hands; Chronic pain syndrome; Previous opioid habituation; Depression/adjustment disorder with anxiety. Primary treating physician progress note dated 07/09/2014 noted patient was following up for neck and low back pain. Symptoms reported as stable. Felt medications were helpful. She reported she had discontinued Cymbalta. Primary physician had trialed fetzima for depression, which patient also discontinued on her own. Pain reported 9/10 without medication, 4/10 with medication. Continued aching in low back and buttocks with burning in her lateral thighs and knees. Stabbing and aching in her rhomboid. Increased pain reported with sitting, bending, lifting, and laying down. 5/5 lower extremity strength documented. Patellar reflexes 2+, Achilles reflexes 1+. Sensation noted as intact. Sciatic notches and sciatic notches were pain-free on palpation, Patrick's and Gaenslen's maneuver were negative, and SLR elicited low back pain. Heel-toe gait normal. Documented medications included Lidoderm patches, MiraLax, ranitidine, naproxen sodium, Suboxone, and prevacid. Amitriptyline was prescribed at this visit to help with sleep, depression, and neuropathic pain.Treatment note dated 07/11/2014 noted the patient had discontinued all antidepressant

medications, including Wellbutrin XL and Cymbalta. She noted that Vicodin seemed to be the only thing which helped, having tried it 4 to 5 days prior to the visit date. It is noted the patient was taking Suboxone at the time. Patient was restarted on Wellbutrin at this visit.Note from clinical pharmacologist regarding potentially serious interaction between Wellbutrin XL and Elavil dated 07/16/2014 noted. Recommendation to combine medications only with extreme caution.Primary treating physician progress note from 08/15/2014 the patient presented for follow-up regarding her neck and low back pain. She had been having increased low back, hip, and thigh pain the last week. She had failed injections in the past. She was not interested in trying any other treatments. She felt medications were helpful and well tolerated, including ranitidine and Lidoderm patches. She reported she was able to perform ADLs with the help of her medications. She was prescribed Suboxone and Wellbutrin through her pain management physician, [redacted], and sees a psychologist in [redacted] office as well. She rated her pain as 9/10 w/o meds and 7/10 with pain medications. She denied any new symptoms or neurological changes. Physical examination documented 5/5 bilateral lower extremity strength, 2+/1+ symmetric reflexes, intact sensation, and normal heel-toe gait. Sciatic notches and sciatic notches were pain-free on palpation, Patrick's and Gaenslen's maneuver were negative, and SLR elicited low back pain. There was tenderness over the lumbar paraspinals and pain with lumbar extension and flexion. Current medications were lansoprazole, ranitidine, Lidoderm patch, MiraLax, naproxen and Suboxone. She was administered a Toradol injection for complaint of increased pain a recommendation was made for massage therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Elavil (Amitriptyline) 25mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tricyclics Page(s): 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Amitriptyline http://reference.medscape.com/drug-interactionchecker

Decision rationale: Amitriptyline is a tricyclic antidepressant. The Medical Utilization Treatment Schedule (MTUS) note that tricyclic's are recommended. They are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. The Official Disability Guidelines (ODG) reflects the MTUS guidelines.According to the medical records, the patient is currently taking Wellbutrin XL. Concomitant administration of Wellbutrin and amitriptyline has potential serious adverse effects, including lowering of seizure threshold, and increased levels of circulating amitriptyline due to inhibition of CYP2D6, which could lead to an increased risk of toxity related to amitriptyline. Medications should be co-administered with extreme caution.Based on the MTUS and ODG recommendations, as well as the above cited drug-drug interaction potential, and given the potential for significant adverse reaction, and availability of safer alternatives to tricyclic's for treated conditions, the request for amitriptyline is not medically necessary.

Lansoprazole cap 30mg #30 (generic): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs: NSAIDs, GI symptoms & cardi.

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

Decision rationale: The Medical Utilization Treatment Schedule (MTUS) guidelines note that proton pump inhibitors (such as lansoprazole) are recommended for patients at risk for gastrointestinal events. Determining factors are 1) age over 65 years, 2) history of peptic ulcer, GI bleeding or perforation, 3) concurrent use of ASA, corticosteroids, and/or an anticoagulants, or 4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The medical documentation notes both a history of Gastroesophageal reflux disease (GERD) which responded to a combination of lansoprazole and ranitidine, and a history of long-term use of naproxen sodium.Based on the MTUS guidelines noted above and the clinical documentation, the requested prescription for lansoprazole is medically necessary.

Lidocaine Patches Lidocaine PAD 5% #90 (generic): 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 Lidoderm (lidocaine patch) Page(s): 56-57.

Decision rationale: The Medical Utilization Treatment Schedule (MTUS guidelines state topical lidocaine in patch form may be recommended for localized peripheral nerve pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants or an anti-epileptic drug such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia.The medical documents mention that the Lidoderm is being prescribed for neuropathic pain, and that the patient finds them helpful however they do not establish that the patient has localized peripheral pain. No subjective report or objective findings consistent with neuropathy are documented as present.Based on the MTUS guidelines and the medical documentation provided, the medical necessity of Lidoderm patches has not been established, and is not supported as medically necessary.