

Case Number:	CM14-0132366		
Date Assigned:	09/19/2014	Date of Injury:	06/08/1999
Decision Date:	10/23/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	08/19/2014

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 Internal Medicine has a subspecialty in Pulmonary Diseases 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 63-year-old female who reported an injury of unknown mechanism on 06/08/1999. On 04/08/2014, her diagnoses included cervical radiculopathy, headache, thoracic or lumbosacral radiculopathy, rotator cuff sprain, neck pain, GERD, chronic pain syndrome, cervical spinal stenosis, nausea, depression, insomnia, migraine, shoulder joint pain, disorders of bursa and tendons in the shoulder, low back pain, lumbar degenerative disc disease, myalgia and myositis unspecified, facet arthropathy, cervical degenerative disc disease, rotator cuff repair, cervical spondylosis without myelopathy, and COAT. Her complaints included upper back, lower back, neck, and left shoulder pain. Her symptoms were aggravated by bending, extension, and lifting. Her symptoms were relieved by lying down, pain medications/drugs, and rest. Her medications included zolpidem 10 mg, Sertraline 100 mg, Zofran 4 mg, Norco elixir 7.5/325 mg/15 mL, Fioricet with codeine 15/325/40/30 mg, Maxalt 10 mg, Prevacid 30 mg, Lidoderm 5% patch, and Voltaren 1% gel. There was no rationale or Request for Authorization included in this worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1 QTY: 500.00 with 4 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Regarding topical anti-inflammatory gel.

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

Decision rationale: The request for Voltaren gel 1 QTY: 500.00 with 4 refills is not medically necessary. The California MTUS Guidelines refer to topical analgesics as primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The only FDA approved NSAID for topical application is Voltaren gel 1% (diclofenac), which is indicated relief of osteoarthritis pain in joints that lend themselves to topical treatment, such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. There was no evidence in the submitted documentation that this worker had a diagnosis of osteoarthritis in any of the joints that lend themselves to topical treatment. Additionally, the body part or parts to have been treated with this gel were not indicated in the request. Furthermore, there was no frequency of application included with the request. Therefore, this request for Voltaren gel 1 QTY: 500.00 with 4 refills is not medically necessary.

Sertraline HCL 100mg QTY: 30.00 with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16.

Decision rationale: The request for Sertraline HCL 100mg QTY: 30.00 with 3 refills is not medically necessary. The California MTUS Guidelines recommend antidepressants as a first line option for neuropathic pain and as a possibility for nonneuropathic pain. Tricyclic antidepressants are generally considered a first line agent unless they are ineffective, poorly tolerated, or contraindicated. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological status. Side effects including excessive sedation should also be assessed. Sertraline is a selective serotonin reuptake inhibitor. They are controversial based on controlled trials. It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. More information is needed regarding the role of SSRIs and pain. The guidelines do not support the use of this medication in pain control. Furthermore, there were no assessments of this medication on pain outcomes, functional abilities, changes in use of other analgesic medications, sleep quality, or side effects. Additionally, the request did not include frequency of administration. Therefore, this request for Sertraline HCL 100mg QTY: 30.00 with 3 refills is not medically necessary.

Maxalt MLT 10mg QTY: 18.00 with 4 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head, Triptans.

Decision rationale: The request for Maxalt MLT 10mg QTY: 18.00 with 4 refills is not medically necessary. The Official Disability Guidelines do recommend triptans for migraine sufferers. In marketed doses, all oral triptans are effective and well tolerated. Maxalt has demonstrated a high response rate and more rapid onset of action than sumatriptan, together with a favorable tolerability profile. Maxalt brand of rizatriptan therapy is more expensive than other triptans. According to the FDA Orange Book, equivalent generics have been approved for Maxalt, so generic rizatriptan would be recommended. The guidelines do not support the use of brand name Maxalt over the generic rizatriptan. Furthermore, there was no frequency of administration included with the request. Therefore, this request for Maxalt MLT 10mg QTY: 18.00 with 4 refills is not medically necessary.

Lidoderm patches 5% QTY: 60.00 with 4 refills: Upheld

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

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

Decision rationale: The request for Lidoderm patches 5% QTY: 60.00 with 4 refills is not medically necessary. The California MTUS Guidelines refer to topical analgesics as primarily being 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 failed trials of first line therapy, including tricyclic or SNRI antidepressants, and an antiepileptic medication such as gabapentin or Lyrica. The only form of FDA approved topical application of lidocaine is the 5% transdermal patch for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. There was no evidence in the submitted documentation that this worker had failed trials of antiepileptic medications or was diagnosed with postherpetic neuralgia. Additionally, the body part or parts to have been treated with the requested patches was not identified in the request. Furthermore, there was no frequency of application. Therefore, this request for Lidoderm patches 5% QTY: 60.00 with 4 refills is not medically necessary.

Hydrocodone/acetaminophen 7.5/325mg/ 15ml QTY: 473.00 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Regarding Criteria For Use Of Opioid for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

Decision rationale: The request for Hydrocodone/acetaminophen 7.5/325mg/ 15ml QTY: 473.00 with 2 refills is not medically necessary. The California MTUS Guidelines recommend

ongoing review of opioid use, including documentation of pain relief, functional status, appropriate medication use, and side effects. It should include current pain and intensity of pain before and after taking the opioid. In most cases, analgesic treatment should begin with acetaminophen, aspirin, NSAIDs, or anticonvulsants. Long term use may result in immunological or endocrine problems. There was no documentation in the submitted chart regarding appropriate long term monitoring/evaluations, including side effects, failed trials of NSAIDs, aspirin or anticonvulsants, quantified efficacy, or drug screens. Additionally, there was no rationale included in this worker's chart as to the need for a liquid medication when all of her other medications were tablets or capsules. Furthermore, there was no frequency of administration included with the request. Since this worker was taking more than 1 opioid medication, without the frequency, the morphine equivalency dosage could not be calculated. Therefore, this request for Hydrocodone/acetaminophen 7.5/325mg/ 15ml QTY: 473.00 with 2 refills is not medically necessary.

Floriset with codeine 50/325/40/30/mg QTY: 60.00 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbituate containing analgesics (BCAs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Page(s): 74-95.

Decision rationale: The request for Floriset with codeine 50/325/40/30/mg QTY: 60.00 with 3 refills is not medically necessary. The California MTUS Guidelines recommend ongoing review of opioid use, including documentation of pain relief, functional status, appropriate medication use, and side effects. It should include current pain and intensity of pain before and after taking the opioid. In most cases, analgesic treatment should begin with acetaminophen, aspirin, NSAIDs, or anticonvulsants. Long term use may result in immunological or endocrine problems. There was no documentation in the submitted chart regarding appropriate long term monitoring/evaluation, including side effects, failed trials of NSAIDs, aspirin or anticonvulsants, quantified efficacy, or drug screens. Furthermore, there was no frequency of administration included with the request. Since this worker was taking more than 1 opioid medication, without the frequency, the morphine equivalency dosage could not be calculated. Therefore, this request for Floriset with codeine 50/325/40/30/mg QTY: 60.00 with 3 refills is not medically necessary.