MAXIMUS Federal Services

Case Number:	CM14-0140991		
Date Assigned:	09/10/2014	Date of Injury:	04/01/2009
Decision Date:	11/05/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/02/2014

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 & Rehabilitation and Pain 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 injured worker is a 49 year old female with a reported date of injury on 04/01/2009. Her mechanism of injury was not reported. Her diagnoses include carpal tunnel syndrome, chronic pain syndrome, and shoulder pain. Her past treatments were reported to be medications, physical therapy, home exercise and stretching. Her diagnostic exams were noted to be an EMG/NVS and a urine drug screen performed on 06/25/14 with inconsistent results and was negative for Norco. On 08/15/14 the injured worker complained of bilateral upper extremity pain at 5/10 with aches and tingling that increases with cold and activity, headaches, insomnia, and severe constipation. She also states that her meds decrease pain greater than 50% which allows her to do activities. The physical exam reported decreased painful flexion by 75% plus tenderness to palpitation over medical epicondyle of right shoulder. Her current medications included Butrans Patch 10 MCG #4, Lidoderm Patch 5% #30, Senekot-S 8.6mg #30 and Horizant 600mg #30 with no side effects. The treatment plan is to discontinue Lidoderm patch per UR denial, prescriptions for Horizant 600mg, 1 tab daily #30, trial e-stem unit for greater than a 50% reduction in pain relief and allows for reduction in oral pain medication and increased activities, a prescription for a trail of Vistaril 25mg 1 tab daily at bedtime #30 for pain related to anxiety and insomnia, a prescription for Amitiza 24mcg, 1 tab daily #30 for constipation, a trial of lidocaine 10% topical cream and to continue at home exercise and stretching. The Request for Authorization form was not included.

IMR ISSUES, DECISIONS AND RATIONALES

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

Horizant 600mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Medications Page(s): 18. Decision based on Non-MTUS Citation FDA

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 16-17.

Decision rationale: The injured worker was diagnosed with carpal tunnel syndrome, chronic pain syndrome, and shoulder pain and sprain. The physical exam noted bilateral upper extremity pain that was worse with cold or activity. The California MTUS Guidelines state that antiepileptic medications such as gabapentin are recommended for neuropathic pain. There was a lack of objective findings to support that the injured worker has neuropathic pain. Additionally, There was no rational provided with the request. Furthermore, the request for Horizant 600mg # 30 did not include a medication frequency. In the absence of the information above the request is not supported by the evidence based guidelines. As such, the request of Horizant 600mg #30 is not medically necessary and appropriate.

Vistaril 25mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Amitiza:Initiation of Opioids Page(s): 77. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 18th Edition (web), 2013, Vistaril: Treatment in Workers Compensation, Pain, Insomnia Treatment

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 physical exam noted that the injured worker had been using Vistaril for anxiety and insomnia related to pain. ODG recommends that the treatment of insomnia be based on the etiology with the medications recommended such as: benzodiazepines, non-benzodiazepine sedative hypnotics, sedating antihistamines over the counter, and melatonin receptor agonist. The guidelines further state that pharmacological agents should be used only after careful evaluation of the potential causes of sleep disturbance and the failure to resolve in a 7 to 10 day period may indicate a psychiatric or medical illness. The documentation failed to provide evidence that addressed the injured workers sleep disturbance specifically, including other treatments for sleep and a psychiatric evaluation was not provided. Furthermore, the request failed to provide the frequency, therefore the request of Vistaril 25mg #30 is not medically necessary and appropriate.

Lidocaine Cream 10% #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 2009, Lidocaine, Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain, Lidoderm Page(s): 56-57.

Decision rationale: The California MTUS Guidelines state that Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy with antidepressants and anticonvulsants have failed. There is no evidence reported to support that antidepressants and anticonvulsant have been prescribed and have failed. The guidelines further state that Lidocaine is primarily used for post-herpetic neuralgia and there is no recommendation in treatment for other chronic neuropathic pain disorders. The guidelines also states that with lidocaine, there is no other commercially approved topical formulations of lidocaine (whether creams, lotions, or gels) that are indicated for neuropathic pain other than the brand name Lidoderm. Thus, due to the lack of documentation to support the failure of antidepressants and anticonvulsants and findings noted on the physical exam of post-herpetic neuralgia, the request for Lidocaine cream is not supported. Based on the above, the request for Lidocaine 10% cream #1 is not medically necessary.