MAXIMUS Federal Services

Case Number:	CM14-0040507		
Date Assigned:	09/10/2014	Date of Injury:	06/15/2000
Decision Date:	10/15/2014	UR Denial Date:	02/26/2014
Priority:	Standard	Application Received:	03/10/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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 56 year old with an injury date on 6/15/00. Patient complains of unchanged cervical pain and lower lumbar pain with radiating leg pain rated 7/10 per 2/4/14 report. Patient also continues with daily cervicogenic headaches from right > left without new arm pain, and his pain is controlled by current medications, stimulator, and the sumavel injections per 2/4/14 report. Based on the 2/4/14 progress report provided by [redacted] the diagnoses are: 1. Chronic lower back pain with leg pain, L1-3 fusion, L4-5 fusion2. Myofascial pain/spasm3. Chronic neck and arm pain4. Cervical spondylosis5. Seizure d/o6. Hypertension7. History of renal failure, 2nd SI attempt8. Chronic analgesic dependency with efficacy9. s/p SCS lami ipg implant; mdt; per [redacted] MD; July 2011, exchanged to ABI 11/1310. Poor sleep hygieneExam on 2/4/14 showed "antalgic gait. Occiput tenderness c/w neck condition. Baseline lumbar paraspinal pain. [redacted] is requesting subsys 400mg #60 from everyday as needed for severe breakthrough pain, Trazadone 50mg #30, Sumarel 1 injection as needed for headaches #9, Lidodderm, Prilosec, Valium, Intermezzo 3.5mg #60, and Lexapro 10mg #30. The utilization review determination being challenged is dated 2/26/14 and denies sumavel injection as it is indicated for migraine headaches, which patient does not present with. [redacted] is the requesting provider, and he provided treatment reports from 9/11/13 to 3/4/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Subsys 400ugm, #60 from everyday as need for severe breakthrough pain, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Criteria for Use of opioids, therapeutic trial of Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list Page(s): 91-94.

Decision rationale: This patient presents with neck pain and lower back pain. The physician has asked for Subsys 400mg #60 from everyday as needed for severe breakthrough pain on2/4/14. Subsys is a sublingual spray for Fentanyl, similar to Fentora and other short acting Fentanyl for immediate release. MTUS specifically states that Fentora is not recommended for chronic pain. These short-term oral swabs, tablets and sprays are not supported by the guidelines for chronic musculoskeletal pain. Recommendation is for denial.

Trazadone 50mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain. Page(s): 13-16. Decision based on Non-MTUS Citation ODG Guidelines, stress/mental chapter, for Trazodone

Decision rationale: This patient presents with neck pain and lower back pain. The physician has asked for Trazadone 50mg #30 on 2/4/14. Patient has been taking Trazadone since 9/11/13 report. Regarding Trazadone, ODG Guidelines recommend as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. In this case, the patient has been taking Trazadone for 4 months without mention of improvement in function and pain. In addition, the patient does not present with a diagnosis of depression or anxiety. The requested Trazadone 50mg #30 is not medically necessary for this patient's condition at this time. Recommendation is for denial.

Sumavel, 1 injection as needed for headaches, #9: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Sumavel (Http://www.drugs.com/sumavel-dosepro.html)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

Decision rationale: This patient presents with neck pain and lower back pain. The physician has asked for Sumavel 1 injection as needed for headaches #9 on 2/4/14. The patient has been using Sumavel since 9/17/13, and the physician states that it is effective in treating cervicogenic headaches. Regarding Sumatriptan aka Imitrex, ODG Recommends for migraine sufferers. At marketed doses, all oral triptans (e.g., Sumatriptan, brand name Imitrex) are effective and well

tolerated. Differences among them are in general relatively small, but clinically relevant for individual patients. In this case, the patient does not present with migrainous headaches. Rather, the patient has cervicogenic headache which is not indicated for Sumeva injections. Recommendation is for denial.

Lidoderm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch); Topical Analgesics Page(s): 56-57; 111-113. Decision based on Non-MTUS Citation ODG, Pain

Decision rationale: This patient presents with neck pain and lower back pain. The physician has asked for Lidodderm on 2/4/14. The patient has been using Lidoderm since 9/17/13 report. MTUS guidelines page 57 states, "topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica)." MTUS Page 112 also states, "Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain." When reading ODG guidelines, it specifies that Lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. In this case, the physician does not document where the patient is using product and with what benefit. The patient also does not present with localized peripheral pain that is neuropathic. MTUS page 60 require documentation of function and pain reduction when medications are used for chronic pain. Recommendation is for denial.

Prilosec: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS and Gastrointestinal Symptoms Page(s): 68.

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

Decision rationale: This patient presents with neck pain and lower back pain. The physician has asked for Prilosec on 2/4/14. Regarding Prilosec, MTUS does not recommend routine prophylactic use along with NSAID. GI risk assessment must be provided. There is no documentation of any GI issues such as GERD, gastritis or PUD. The physician does not explain why this medication needs to be continued other than for presumed stomach upset. MTUS does not support prophylactic use of PPI without GI assessment. The patient currently has no documented stomach issues. Recommendation is for denial.

Valium 5mg, #60: Upheld

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

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

Decision rationale: This patient presents with neck pain and lower back pain. The physician has asked for valium on 2/4/14. Regarding benzodiazepines, MTUS recommends for a maximum of 4 weeks, as long-term efficacy is unproven and there is a risk of dependence. In this case, the requested valium is not indicated for this patient's condition. Recommendation is for denial.

Intermezzo 3.5mg, #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Integrated Treatment/Disability Duration Guidelines, Stress and Mental Illness Chapter, Zolpidem

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC guidelines, Chronic Pain Chapter

Decision rationale: This patient presents with neck pain and lower back pain. The physician has asked for Intermezzo 3.5mg #60 on 2/4/14. The patient has been taking Ambien since 9/17/13 report. Regarding Ambien, ODG guidelines recommend for the short-term treatment (2 to 6 week period) of insomnia with difficulty of sleep onset (7-10 days). Not recommended for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. In this case, the patient has been taking Ambien for over 4 months but it is only indicated for short-term use (7-10 days). The requested Intermezzo 3.5mg #60 is not medically necessary. Recommendation is for denial.

Lexapro 10mg, #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Selective serotonin reuptake inhibitor (SSNRI).

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

Decision rationale: This patient presents with neck pain and lower back pain. The physician has asked for Lexapro 10mg #30 on 2/4/14. The patient has no history of taking Lexapro. Escitalopram (Lexapro, no generic available) is an SSRI. Regarding antidepressants, MTUS recommends for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to

a week, whereas antidepressant effect takes longer to occur. (Saarto-Cochrane, 2005) 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 assessment. It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. In this case, the physician is requesting a trial of Lexapro 10mg #30 which is reasonable for patient's ongoing neuropathic pain. Recommendation is for authorization.