

Case Number:	CM14-0047244		
Date Assigned:	09/10/2014	Date of Injury:	07/22/1994
Decision Date:	10/29/2014	UR Denial Date:	04/04/2014
Priority:	Standard	Application Received:	04/15/2014

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 Pain Management 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:

This is a female patient with the date of injury of July 22, 1994. A Utilization Review was performed on April 4, 2014 and recommended non-certification of Cymbalta 60mg #60, Clonidine 0.1mg, Celebrex 100mg #60, Tizanidine 2mg #100, Thermacare heat 1g/x1 #30, Provigil 100mg #60, Lidoderm patches #30 and Abilify 2mg #30 and modification of Lorazepam 2mg #60 and Tramadol 50mg #75. No progress reports were provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cymbalta (60mg, #60): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Selective Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs).

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

Decision rationale: Regarding the request for duloxetine (Cymbalta), guidelines state that antidepressants are recommended as a 1st line option for neuropathic pain and as a possibility for non-neuropathic pain. Guidelines go on to recommend a trial of at least 4 weeks. 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. Within the documentation available for review, there is no identification that the Cymbalta provides any specific analgesic effect (in terms of reduced numeric rating scale or percent reduction in pain), or provides any objective functional improvement, reduction in opiate medication use, or improvement in psychological well-being. Additionally, if the Cymbalta is being prescribed to treat depression, there is no documentation of depression, and no objective findings which would support such a diagnosis (such as a mini mental status exam, or even depressed mood). In the absence of clarity regarding those issues, the currently requested duloxetine (Cymbalta) is not medically necessary.

Clonidine (0.1mg): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Clonidine, Intrathecal.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Clonidine, Intrathecal Page(s): 34.

Decision rationale: Regarding the request for Clonidine, Chronic Pain Medical Treatment Guidelines state intrathecal Clonidine is recommended only after a short-term trial indicates pain relief in patients refractory to opioid monotherapy or opioids with local anesthetic. Within the information made available for review, there is no indication that pain relief has been refractory to opioid monotherapy or opioids with local anesthetic. There is no mention of a short-term trial. In the absence of such documentation, the currently requested Clonidine is not medically necessary.

Celebrex (100mg, #60): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications, Celebrex Page(s): 22, 30.

Decision rationale: Regarding the request for celecoxib (Celebrex), Chronic Pain Medical Treatment Guidelines state that Celebrex may be considered if the patient has a risk of GI complications. Within the documentation available for review, there is no identification of a high risk of GI complications. There is no indication that Celebrex is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested celecoxib (Celebrex) is not medically necessary.

Tizanidine (2mg, #100): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: Regarding the request for tizanidine (Zanaflex), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that tizanidine specifically is FDA approved for management of spasticity; unlabeled use for low back pain. Guidelines recommend Liver Function Test monitoring at baseline, 1, 3, and 6 months. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the tizanidine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, it does not appear that there has been appropriate liver function testing, as recommended by guidelines. In the absence of such documentation, the currently requested tizanidine (Zanaflex), is not medically necessary.

ThermaCare Heat (1g/x1, #30): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Cold/Heat Packs

Decision rationale: Regarding the request for Thermacare heat pads, Occupational Medicine Practice Guidelines state that various modalities such as heating have insufficient testing to determine their effectiveness, but they may have some value in the short term if used in conjunction with the program of functional restoration. The Official Disability Guidelines state that heat/cold packs are recommended as an option for acute pain. Within the documentation available for review, and there is no indication that the patient has acute pain. Additionally, it is unclear what program of functional restoration the patient is currently participating in which would be used alongside the currently requested heat pad. In the absence of clarity regarding those issues, the currently requested Thermacare heat pads are not medically necessary.

Provigil (100mg, #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): Pain, Provigil

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 Chapter, Armodafinil (Nuvigil)

Decision rationale: Regarding the request for Provigil, California MTUS and ACOEM Practice Guidelines do not contain criteria for the use of Provigil, the Official Disability Guidelines states

the Provigil is not recommended solely to counteract sedation effects of narcotics. Provigil is used to treat excessive sleepiness caused by narcolepsy or shift work sleep disorder. Within the documentation available for review, there is no indication that the patient has narcolepsy or shift work sleep disorder. In the absence of such documentation, the currently requested Provigil is not medically necessary.

Lidoderm Patches (#30): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

Decision rationale: Regarding request for topical lidoderm, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Additionally, there is no documentation of analgesic effect or objective functional improvement as a result of the currently prescribed lidoderm. Finally, there is no documentation of localized peripheral pain as recommended by guidelines. As such, the currently requested lidoderm is not medically necessary.

Abilify (2mg, #30): 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): Mental Stress - Abilify

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, Aripiprazole (Abilify)

Decision rationale: Regarding the request for Abilify, California MTUS guidelines do not contain criteria for the use of Abilify. The Official Disability Guidelines states Abilify is not recommended as a first-line treatment. Abilify (aripiprazole) is an antipsychotic medication. Antipsychotics are the first-line psychiatric treatment for psychotic disorders such as schizophrenia. Within the information made available for review, a diagnosis of schizophrenia, or any other psychotic disorder is not identified. In the absence of such documentation, the currently requested Abilify is not medically necessary.

Lorazepam (2mg, #60): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Benzodiazepines.

Decision rationale: Regarding the request for Ativan (lorazepam), Chronic Pain Medical Treatment Guidelines state the benzodiazepines are "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks... Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant." Within the documentation available for review, there is no documentation identifying any objective functional improvement as a result of the use of the medication and no rationale provided for long-term use of the medication despite the California MTUS guideline recommendation against long-term use. Benzodiazepines should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In the absence of such documentation, the currently requested Ativan (lorazepam) is not medically necessary.

Tramadol (40mg, #75): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 44, 47, 75-79, 120.

Decision rationale: Regarding the request for Ultram (tramadol), California Pain Medical Treatment Guidelines state that Ultram is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Ultram (tramadol), is not medically necessary.