

Case Number:	CM14-0068057		
Date Assigned:	08/06/2014	Date of Injury:	11/19/1999
Decision Date:	09/16/2014	UR Denial Date:	03/07/2014
Priority:	Standard	Application Received:	04/01/2014

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 and is licensed to practice in both California and Washington. 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 71-year-old male who reported an injury on 04/13/1998. On 02/14/2014, the injured worker presented with lower back pain. Current medications included Lidoderm patch, Neurontin, Protonix, Seroquel, Trazodone, Zanaflex, and Norco. Upon examination of the lumbar spine there was restricted range of motion and tenderness and spasm upon palpation over the paravertebral muscles with a tight muscle band and trigger points with a twitch response noted bilaterally. There was positive facet loading and tenderness noted over the sacroiliac spine. Examination of the right knee noted tenderness to palpation over the lateral joint line and medial joint line. Examination of the left knee noted tenderness to palpation over the lateral and medial joint line and mild effusion of the left knee joint. There was decreased sensation over the lateral foot and lateral calf of the left side. The diagnoses were piriformis syndrome, pain in the joint lower leg, low back pain, and spinal/lumbar degenerative disc disease. The provider recommended Trazodone, Lidoderm patches, Protonix, Seroquel, and Zanaflex; the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazadone 50 mg #60, Refills x2: 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: Sedating Antidepressants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress, Trazadone.

Decision rationale: The California MTUS Guidelines recommend "antidepressants as a first-line option for neuropathic pain, and as a possibility for non-neuropathic pain. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of analgesic medication, and sleep quality and duration. Side effects including excessive sedation, especially that which would affect work performance should be assessed." The Official Disability Guidelines further state that "Trazodone is recommended as an option for insomnia for injured workers with potentially coexisting mild psychiatric symptoms, such as depression or anxiety." There is limited evidence to support the use for insomnia, but it may be an option for injured workers with coexisting depression. There is a lack of documentation on if the injured worker has coexisting depression. Additionally, the injured worker has been prescribed Trazodone and the efficacy of the medication has not been provided. The provider did not indicate the frequency of the medication in the request as submitted. As such, the request is considered not medically necessary.

Norco 10/325 mg, Refills x2: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend the use of opioids for the ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risks for aberrant drug abuse behavior, and side effects. Additionally, the efficacy of the prior use of Norco has not been provided. The provider did not indicate the frequency of the medication in the request as submitted. As such, the request is considered not medically necessary.

Lidoderm Patches 5% #30, Refills x2: 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 Page(s): 57.

Decision rationale: The California MTUS states "topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of a first-line therapy tricyclic or SNRI antidepressant or an AED such as gabapentin or Lyrica." This is not a first-line treatment and is only FDA-approved for postherpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. The injured worker does not have a diagnosis congruent with the guideline recommendation for Lidoderm patches. Additionally, the site that the Lidoderm patch is indicated for and the frequency of the medication were not provided in the request as submitted. As such, the request is considered not medically necessary.

Protonix 20 mg #30, Refills x2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68.

Decision rationale: According to the California MTUS Guidelines, "Protonix may be recommended for injured workers with dyspepsia secondary to NSAID therapy or for those taking NSAID medications who are at moderate to high risk for gastrointestinal events." The injured worker does not have a diagnosis congruent with the guideline recommendation for a proton pump inhibitor. Additionally, the injured worker is not at moderate to high risk for gastrointestinal events. The efficacy of the prior use of Protonix has not been provided. Additionally, the provider's request does not indicate the frequency of the medication in the request as submitted. As such, the request is not considered medically necessary.

Seroquel 25 mg #30, Refills x2: 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): PTSD Pharmacotherapy, Mental Illness & Stress.

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

Decision rationale: The Official Disability Guidelines do not recommend Seroquel as a first-line treatment. There is insufficient evidence to recommend an atypical antipsychotic for conditions covered in ODG. Additionally, adding an atypical antipsychotic to an antidepressant provides limited improvement in depressive symptoms in adults. As the guidelines do not recommend Seroquel for first-line treatment, the medication would not be indicated. Additionally, the injured worker does not have a diagnosis congruent with the guideline recommendations for Seroquel. The provider's request does not indicate the frequency of the medication in the request as submitted. As such, the request is considered not medically necessary.

Zanaflex 4 mg #60, Refills x2: 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 Relaxant Page(s): 63.

Decision rationale: The California MTUS Guidelines recommend "Non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations. They show no benefit beyond NSAIDs in pain and overall improvement, and efficacy appears to diminish over time. Prolonged use of some medications in this class may lead to dependence." The provider's request for Zanaflex 4 mg with a quantity of 60 and 2 refills exceed the guideline recommendation for short-term treatment. Additionally, the frequency of the medication was not submitted in the request. As such, the request is considered not medically necessary.

