

Case Number:	CM14-0070180		
Date Assigned:	07/14/2014	Date of Injury:	12/12/2007
Decision Date:	09/19/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/15/2014

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 Family 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:

This is a 68 year old female patient who reported an industrial injury on 12/12/2007, almost 7 years ago, attributed to the performance of her usual and customary job tasks. The patient is noted to be status post right shoulder surgery. The patient complains of neck and right shoulder pain. The MRI of the cervical spine dated 11/27/2013 is reported to document multilevel this degenerative disease with multilevel foraminal encroachment. The patient noted improvement to the right shoulder subsequent to the provided corticosteroid injection. The objective findings on examination included positive impingement signs to the right shoulder; tenderness to palpation. The treating diagnosis is right shoulder impingement s/p arthroscopic surgical intervention. The patient has been prescribed/dispensed Lyrica 75 mg #30; Lunesta 3 mg #30; Lidoderm patches #60 on 4/25/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lyrica 75mg #30 per 4/25/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99-127.

MAXIMUS guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Pregabalin (Lyrica) page 99 Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter AEDs; Non-MTUS American College of

Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chronic pain chapter revised 8/8/08 page 110.

Decision rationale: The patient was prescribed Lyrica based without evidence of neuropathic pain; however, there are no documented objective findings consistent with neuropathic pain to the post-operative right shoulder. The patient has subjective findings that are non-focal. The patient was not demonstrated to have been previously prescribed Gabapentin (Neurontin) and there is no documented neuropathic pain issue. The patient is not documented to have neuropathic pain. There is no documented nerve impingement radiculopathy or neurological deficits along a dermatomal distribution. The patient has been treated for postoperative right shoulder pain. The PTP has speculated that the subjective symptoms are consistent with neuropathic pain; however, does not provide objective findings on examination to support the presence of neuropathic pain for the cited diagnoses. The diagnoses do not support the medical necessity for prescribed Lyrica. The treating physician has provided this medication for the daily management of this patient's chronic pain reported as neuropathic pain. The prescription of Lyrica is recommended for neuropathic pain; however, the ACOEM Guidelines does not specifically recommend Lyrica for the treatment of chronic non-neuropathic pain. Gabapentin or pregabalin is not recommended for treatment of chronic, non-neuropathic pain by the ACOEM Guidelines. It is clear that there is no documentation of significant neuropathic pain for this patient. The ACOEM Guidelines revised chronic pain chapter states that there is insufficient evidence for the use of Gabapentin or Lyrica for the treatment of axial lower back pain; chronic lower back pain; or chronic lower back pain with radiculopathy. The CA MTUS and the Official Disability Guidelines state that there is insufficient evidence to support the use of Gabapentin or Lyrica for the treatment of chronic axial lower back pain. The use of Lyrica is for neuropathic pain; however, evidence based guidelines do not recommend the prescription of Lyrica for chronic lower back pain with a subjective or objective radiculopathy and favors alternative treatment. There is no demonstrated medical necessity for the prescribed Lyrica 75 mg #30 as dispensed on 4/25/2014 for the treatment of the effects of the industrial injury. Given the above the request is not medically necessary.

Lunesta 3mg #30 per 4/25/14: Upheld

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

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

Decision rationale: The California MTUS and the ACOEM guidelines are silent as to the use of sleeping medications. The prescription for Lunesta is recommended only for the short-term treatment of insomnia for two to six weeks by the ODG. The patient is being prescribed the Lunesta on a routine basis. There is no provided subjective/objective evidence to support the prescription for the use of Lunesta on an industrial basis for this patient for the ongoing prolonged period of time. The patient has exceeded the recommended time period for the use of this short-term sleep aide. There is no medical necessity for the prescription of Lunesta on a

nightly basis. There is no rationale to support the #30 per month Lunesta for the insomnia associated with chronic pain. The patient has been prescribed a sedative hypnotic for a prolonged period time and has exceeded the time period recommended by evidence-based guidelines. The continued use of Lunesta on a nightly basis is inconsistent with evidence-based medicine and is not effective for the patient leading to dependency issues. There is no recommendation for Lunesta for any sleep disturbance issue or for insomnia. The patient has been prescribed Lunesta for a period of time without any documentation of a failure of the multiple available over-the-counter sleep aids. The patient should be discontinued from the recently prescribed Lunesta in favor of other available remedies that may be obtained over the counter. There needs to be further documentation in the medical record that the insomnia is persistent or related to the industrial injury. The patient is prescribed a sedative hypnotic on a nightly basis and not PRN insomnia. The request for Lunesta 3 mg #90 suggest the patient is taking a sleeping medication every night for the next 3 months. There is no demonstrated medical necessity for the use of Lunesta when only short-term treatment is recommended by evidence guidelines. The use of nightly sleeping aids is not medically necessary. The sedative hypnotic is known to lead to issues of dependency and abuse. There is no demonstrated medical necessity for the continuation of Lunesta 3 mg #30 as dispensed on 4/25/2014. Given the above the request is not medically necessary.

Lidoderm patch #60 per 4/25/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines anti-inflammatory medications, topical analgesics Page(s): 67-68; 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter medications for chronic pain; topical analgesics.

Decision rationale: The prescription of topical Lidoderm patches 5% #60 was not demonstrated to be medically necessary and no objective evidence to support the medical necessity of the prescribed topical lidocaine for the cited diagnoses. The CA MTUS does not recommend the use of Lidoderm patches for pain control as the patches or ointment are only FDA approved for the treatment of neuropathic pain attributed to post herpetic neuralgia. The patient is being treated with Lidoderm patches for chronic shoulder pain. There is no medical necessity for the use of the Lidoderm patches for the objective findings documented on examination. The request for authorization of the Lidoderm patches is not supported with objective evidence and is not recommended as a first line treatment for the treatment of chronic neck pain. There is no objective evidence that the Lidoderm patches are more effective than the many available alternatives for the treatment of chronic pain. There is no objective evidence to support the use of Lidoderm patches for the stated symptoms, as there are available alternatives. There is no objective evidence to support the use of topical lidocaine for the treatment of the documented diagnoses. The applicable evidence based guidelines state that more research is required prior to endorsing the use of Lidoderm patches for the treatment of chronic pain. The prescription of Lidoderm patches is FDA approved only for post herpetic neuralgia and is not to be used as a first line treatment. The provider provides no rationale for the use of the dispensed/prescribed

Lidoderm patches over the readily available medical alternatives. The prescription of the Lidoderm patches is inconsistent with evidence-based guidelines. There are no prescribed antidepressants or gabapentin to support the medical necessity of Lidoderm topical patches. Evidence based guidelines necessitate documentation of 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) to support the medical necessity of Lidoderm patch. The patient is not taking Neurontin, thus Lidoderm is not appropriate for the treatment of this patient. There is no objective evidence to support the use of Lidoderm patches for the continuous and daily treatment of chronic neck or back pain. There is no current clinical documentation that indicates that the patient has a localized area of neuropathic pain for which this medication would be medically necessary. There is no demonstrated medical necessity for Lidoderm patches or topical lidocaine ointment to treat the effects of the industrial injury. ODG identifies that Lidoderm is the brand name for a lidocaine patch produced by [REDACTED]. 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). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. Additionally, ODG states that topical lidocaine 5% patch/ointment has been approved by the FDA for post-herpetic neuralgia, and is used off-label for diabetic neuropathy and other neuropathic pain. It has been shown to be useful in treating various chronic neuropathic pain conditions in open-label trials. (Argoff, 2006) (ODG, Pain Chapter). There is no demonstrated medical necessity for the prescribed Lidoderm patches 1% #60 as dispensed to the patient on 4/25/2014. Given the above the request is not medically necessary.