MAXIMUS Federal Services

Case Number:	CM14-0075315		
Date Assigned:	07/16/2014	Date of Injury:	07/18/2003
Decision Date:	09/17/2014	UR Denial Date:	04/16/2014
Priority:	Standard	Application Received:	05/23/2014

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 Occupational 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 patient is a 61-year-old female who has submitted a claim for pain in shoulder joint associated with an industrial injury date of 07/18/2003.Medical records from 12/09/2013 to 05/13/2014 were reviewed and showed that patient complained of right shoulder pain (worse with activity) graded 8-9/10. The patient was unable to sleep well due to pain (03/05/2014). Physical examination revealed tenderness of the right AC (acromioclavicular) joint and limited ROM (range of motion) in all planes of movement. Positive impingement and cross arm tests of the right shoulder was noted. Right shoulder MRI (10/03/2013) revealed subacromial decompression and extensive calcific tendinitis. Of note, there were no complaints of gastrointestinal disturbances (03/05/2014). Treatment to date has included arthroscopic right shoulder subacromial decompression (2006), rest, ice applications, Lidoderm 5% patch 700mg/patch #90 (prescribed 12/09/2013), Norflex ER 100mg #90 (prescribed 12/09/2013), Protonix 20mg #60 (prescribed 12/09/2013) , Ambien 10mg tablet #30 (prescribed 12/09/2013) , and Buprenorphine HCL. Utilization review dated 04/16/2014 denied the request for Lidoderm patch because neither lidocaine ointment nor a 5% lidocaine patch has any evidence-based proven role in the treatment of failed back surgery syndrome or chronic intractable lumbar backache. Utilization review dated 04/16/2014 denied the request for Orphenadrine ER 100mg #90 because muscle relaxants have no proven role in treatment of chronic pain syndrome. Utilization review dated 04/16/2014 denied the request for Protonix 20mg #60 because there were no GI side effects secondary to prolonged use of multiple medications. Utilization review dated 04/16/2014 denied the request for Ambien 10mg #30 because the claimant does not have chronic insomnia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm 5% patch, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch).

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

Decision rationale: As stated on page 56-57 of the California MTUS Chronic Pain Medical Treatment Guidelines, Lidoderm patch is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI (serotonin-norepinephrine reuptake inhibitors) anti-depressants or an AED (anti-epilepsy drug) such as gabapentin or Lyrica). In this case, the patient was prescribed Lidoderm 5% patch 700mg/patch #90 since 12/09/2013. There was no documentation of a trial of first-line therapy in order to support Lidoderm patch use. The medical necessity cannot be established due to insufficient information. Therefore, the request for Lidoderm 5% patch, #90 is not medically necessary.

Orphenadrine (Norflex) ER (extended release) 100mg, #90: 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 Page(s): 63.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP (low back pain). They show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. In this case, the patient was prescribed Norflex ER 100mg #90 since 12/09/2013 for muscle spasms. Physical examination findings did not provide evidence of spasms. Moreover, the long-term use of muscle relaxants is not recommended by the guidelines. There is no discussion as to why variance from the guidelines is needed. Therefore, the request for Orphenadrine (Norflex) ER (extended release) 100mg, #90 is not medically necessary.

Pantoprazole (Protonix) 20mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), gastrointestinal symptoms and cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines NSAIDS, GI Symptoms and Cardiovascular Risk Page(s): 68.

Decision rationale: As stated on page 68 of Chronic Pain Medical Treatment Guidelines, clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors: age > 65 years, history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; or on high-dose/multiple NSAIDs. Patients with intermediate risk factors should be started with proton pump inhibitor. In this case, the patient was prescribed Protonix 20mg #60 since 12/09/2013 for GI prophylaxis. However, there was no documentation of gastrointestinal disturbances. The patient does not classify under those at intermediate risk for gastrointestinal events. Therefore, the request for Pantoprazole (Protonix) 20mg, #60 is not medically necessary.

Ambien 10mg, #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), Pain: Zolpidem (Ambien).

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, Zolpidem.

Decision rationale: CA MTUS does not specifically address zolpidem. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. While sleeping pills are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming and they may impair function and memory. There is also concern that they may increase pain and depression over the long term. In this case, the patient was prescribed Ambien 10mg tablet #30 since 12/09/2013 for sleeplessness. It was noted that the patient still had trouble sleeping despite Ambien intake (03/05/2014). Furthermore, the guidelines do not recommend use of zolpidem beyond six weeks. There was no discussion as to why variance from the guidelines is needed. Therefore, the request for Ambien 10mg, #30 is not medically necessary.