

Case Number:	CM14-0093500		
Date Assigned:	07/25/2014	Date of Injury:	06/24/2012
Decision Date:	09/12/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	06/19/2014

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 and is licensed to practice in Ohio and Texas. 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 67-year-old male who reported an injury on 06/24/2012 due to an unknown mechanism. The injured worker was diagnosed with displacement of lumbar intervertebral disc without myelopathy, depressive disorder, and chronic pain syndromes. Prior treatments were no indicated within the provided documentation. No diagnostic studies were included within the documentation. On 04/29/2014, the physician noted the injured worker ambulated with a slow antalgic gait. The injured worker presented with no acute distress. The physician noted the lower lumbar region was tender to palpation over the right side of the lower lumbar region. The injured worker reported pain rated 7/10. The injured worker also stated that he had depression, anxiety, and sleep disturbances associated with pain, specifically muscle aches and weakness and lower back pain. The injured worker told his physician he was going to the gym to exercise, swim in the pool, and he was making efforts to walk or hike as tolerated. The injured worker stated the pain was constant but variable in intensity and he had radiating pain to the bilateral lower extremities with pain to the right side being greater than left. The injured worker received etodolac, Lidoderm 5% patches, Norco, trazodone, and Voltaren 1% topical gel. The physician recommended treating the injured worker with medications, psychology, and physical therapy. The physician was requesting trazodone 50 mg #60 with 1 refill, Voltaren 1% topical gel, and Lidoderm 5% 700 mg patches. The provider recommended trazodone to assist with sleep and Voltaren and Lidoderm to help alleviate pain to the lower back. The Request for Authorization form was signed on 05/05/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trazodone 50mg #60 with one refill: Upheld

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

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

Decision rationale: The request for trazodone 50 mg #60 with 1 refill is not medically necessary. The Official Disability Guidelines recommend trazodone as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. Evidence for the off-label use of trazodone for treatment of insomnia is weak. The current recommendation is to utilize a combined pharmacologic and psychological and behavior treatment when primary insomnia is diagnosed. There is no clear-cut evidence to recommend trazodone first-line treatment for primary insomnia. The injured worker has been diagnosed with depression. The injured worker has been seen by a psychologist who recommended psychopharmacologic consultation. The physician is utilizing this medication for insomnia, as noted in an office visit on 04/29/2014. The documentation only includes this office visit and gives no history to prior medications used for insomnia and depressive disorder. The injured worker also stated that he had depression, anxiety, and sleep disturbances associated with pain, specifically muscle aches and weakness and lower back pain. The physician did not ascertain the efficacy of this medication related to quality of sleep with or without this medication. Limited documentation did not list how long the injured worker had used this medication, whether there were side effects, improved sleep, or how often the injured worker needed to take this medication. The injured worker made unspecified complaints of insomnia; the physician did not list insomnia as a primary diagnosis. Official Disability Guidelines for trazodone recommend this medication as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. The request as submitted did not include the frequency of the medication. As such, the request is not medically necessary.

Voltaren 1% Topical Gel 100gm #3: Upheld

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

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

Decision rationale: The request for Voltaren 1% topical gel 100 mg #3 is non-certified. The California MTUS Guidelines state Voltaren gel 1% is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment including the ankle, elbow, foot, hand, knee and wrist. It has not been evaluated for the treatment of the spine, hip, or shoulder. There is no indication that the injured worker has a diagnosis of osteoarthritis to a joint amenable to topical treatment. Within the documentation it is noted the physician recommended Voltaren gel

be applied to the lower back for pain relief. The guidelines do not recommend the use of voltaren for topical application to the low back. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. As such, the request is not medically necessary.

Lipoderm 5% 700mg patch #30 with one refill:

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

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

Decision rationale: The request for Lidoderm 5% 700 mg patch #30 with 1 refill is non-certified. The California MTUS guidelines note, topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy including tricyclic or SNRI anti-depressants or an antiepilepsy drug 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. Lidoderm is also used off-label for diabetic neuropathy. The guidelines note the use of Lidoderm for non-neuropathic pain is not recommended. Within the documentation on 04/29/2014, it is noted the physician recommends this trial treatment of Lidoderm patches to be applied to the lower back for pain relief. However, there has been no diagnosis specifically relating to neuropathic pain at this time. There is a lack of documentation indicating whether first line treatments of antidepressants and anti-epileptic drugs were tried and failed as per MTUS guidelines. The frequency of the medication was not provided in the request as submitted. As such, the request is not medically necessary.