

Case Number:	CM14-0192533		
Date Assigned:	11/26/2014	Date of Injury:	12/01/2006
Decision Date:	01/13/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/18/2014

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 Internal Medicine and is licensed to practice in New York. 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 47 year old female legal secretary with a date of injury of 12/01/2006. She had no specific injury but cumulative trauma and had neck base pain and right shoulder blade pain. On 04/10/2007 a magnetic resonance imaging (MRI) of the cervical spine revealed trace bulge at C4-C% with no central canal stenosis or foraminal stenosis. On 04/29/2008 the NCS/EMG of the right upper extremity was normal. On 12/02/2009 she had a right shoulder sprain and neck sprain. On 01/05/2010 a Electromyogram (EMG) and Nerve Conduction Velocity (NCV) Studies of both upper extremities was normal. On 07/24/2012 a MRI of the right shoulder revealed supraspinatus and infraspinatus tendinosis without tear. There was no labral tear. The MRI was unchanged compared to a previous study. On 11/20/2012 Soma and Lidoderm were non-certified. Oxycontin was to be weaned. On 11/30/2012 Nuvigil and Ambien was non-certified. On 06/04/2013 Soma was again non-certified and Oxycontin was again to be discontinued and weaned. The provider continued to prescribe non-certified medication. On 09/16/2013 Rozerem and Lidocaine patch were again non-certified; Soma and Oxycontin were to be weaned. On 03/11/2014, 04/15/2014 and 06/02/2014 medications were non-certified or to be weaned. Despite AP contact, non-certified medications continue to be prescribed and the doses (Oxycontin 30 mg 3 tablets twice a day #270) exceed maximum MTUS doses. On 01/29/2014 the patient had neck pain, upper back pain and right shoulder pain. She noted shaking when taking Nuvigil. She had difficulty sleeping. She continues to smoke cigarettes. Her medications included Nuvigil, Soma, Oxycontin 30 mg three tabs BID, Rozerem, Soma, Lidoderm patch, Voltaren gel and Cymbalta. Gait was normal. Muscle strength was normal. Cervical range of motion was decreased. Spurling maneuver caused no radicular signs. She had cervical paravertebral muscle tenderness. She had right shoulder tenderness with a positive Hawkin's sign. Shoulder cross over was negative. Sensory exam was normal. She was to continue her home exercise program. On

02/06/2014 the PR-2 listed diagnosis included cervical radiculopathy, neck pain, muscle spasm, shoulder pain and mood disorder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm 5% patch, 12 hrs on/12 hrs off, #30, one refill, prescribed 10/15/14: 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, 112.

Decision rationale: California MTUS, Chronic Pain notes that Lidoderm patch is only FDA approved for post herpetic neuralgia. Further research is needed to ascertain if Lidoderm patch is effective against other neuropathic pain. Although this patient has at times a listed diagnosis of cervical radiculopathy, Spurlings maneuver did not cause radiculopathy symptoms and EMG/NCS was normal twice. There is no documentation that this patient had post herpetic neuralgia or any neuropathic pain. Lidoderm patch is not recommended for non-neuropathic pain (page 112, Chronic Pain).

Rozerem 8mg, 1 at bedtime, #30, prescribed 10/15/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MEDLINE PLUS: 4/1/2010 and Official Disability Guidelines (ODG), Pain Chapter, Sedative hypnotics

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Rozerem FDA approved package insert.

Decision rationale: Long term use of Rozerem is not recommended. Also, Rozerem is FDA approved for sleep onset insomnia. The patient has difficulty remaining asleep because of pain. There is no documentation of a primary sleep disorder.

Nuvigil 250mg, 1 daily, #30, prescribed, 10/15/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Armodafinil (Nuvigil); Cephalon, Inc. (May 2009) NUVIGIL (Armodafinil) and RxList.com: <http://www.rxlist.com/nuvigil-drug.htm>

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Nuvigil FDA approved package insert.

Decision rationale: There is no documentation of a FDA approved indication for Nuvigil. There is no documentation of Narcolepsy or idiopathic hypersomnia. The use of Nuvigil for opiate induced fatigue is experimental and investigational treatment. Also, there is no reason to use Nuvigil to stay awake and then Rozerem for sleep onset insomnia.

Soma 350mg, 1 twice daily, as needed, #60, prescribed 10/15/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) and Carisoprodol (Soma).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29.

Decision rationale: This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Carisoprodol is now scheduled in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. In regular abusers the main concern is the accumulation of meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. This includes the following: (1) increasing sedation of benzodiazepines or alcohol; (2) use to prevent side effects of cocaine; (3) use with tramadol to produce relaxation and euphoria; (4) as a combination with hydrocodone, an effect that some abusers claim is similar to heroin (referred to as a "Las Vegas Cocktail"); & (5) as a combination with codeine (referred to as "Soma Coma"). (Reeves, 1999) (Reeves, 2001) (Reeves, 2008) (Schears, 2004) There was a 300% increase in numbers of emergency room episodes related to carisoprodol from 1994 to 2005. (DHSS, 2005) Intoxication appears to include subdued consciousness, decreased cognitive function, and abnormalities of the eyes, vestibular function, appearance, gait and motor function. Intoxication includes the effects of both carisoprodol and meprobamate, both of which act on different neurotransmitters. (Bramness, 2007) (Bramness, 2004) A withdrawal syndrome has been documented that consists of insomnia, vomiting, tremors, muscle twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. This is similar to withdrawal from meprobamate. (Reeves, 2007) (Reeves, 2004) There is little research in terms of weaning of high dose carisoprodol and there is no standard treatment regimen for patients with known dependence. Most treatment includes treatment for symptomatic complaints of withdrawal. Another option is to switch to phenobarbital to prevent withdrawal with subsequent tapering. A maximum dose of phenobarbital is 500 mg/day and the taper is 30 mg/day with a slower taper in an outpatient setting. Tapering should be individualized for each patient. (Boothby, 2003).