

Case Number:	CM14-0197412		
Date Assigned:	12/05/2014	Date of Injury:	08/30/2006
Decision Date:	01/16/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/24/2014

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 North Carolina. 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 58-year-old with a reported date of injury of 08/30/2006. The patient has the diagnoses of degenerative disc disease of the cervical and lumbar spine, right shoulder adhesive capsulitis and status post partial right rotator cuff repair surgery, headaches, chronic pain syndrome and bilateral knee chondromalacia patella and degenerative disc disease. Per the progress notes provided for review from the primary treating physician dated 09/15/2014, the patient had complaints of persistent neck and back pain and headaches. Previous treatment modalities have included acupuncture, chiropractic care and physical therapy. The physical exam noted decreased cervical range of motion, tenderness in the bilateral trapezius muscles, decreased sensation in the right C5-C8 dermatomes and normal muscle strength. The lumbar spine exam noted spinal tenderness, decreased range of motion and decreased sensation in the right L-S1 dermatome. The treatment plan recommendations included continuation of home exercise and continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibprofuen 800mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 71-73.

Decision rationale: The California Chronic Pain Medical Treatment Guideline section on NSAID therapy states: Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with Naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. This medication is recommended at the lowest possible dose for the shortest period of time. The duration of "shortest period of time" is not defined in the California MTUS. The patient has no mentioned cardiovascular, renovascular or gastrointestinal side-effects or risk factors. The dosage prescribed is within recommendations and has been reported to decrease the patient's pain by 25%. Therefore the request is medically necessary.

One box of Lidoderm patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines section on topical lidocaine states: Lidocaine Indication: Neuropathic pain 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). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritics. 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-pruritic. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. (Argoff, 2006) (Dworkin, 2007) (Khaliq-Cochrane, 2007) (Knotkova, 2007) (Lexi-Comp, 2008) Non-neuropathic pain: Not recommended. There is only

one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. This medication is recommended for localized peripheral pain. The patient has had a trial of the SNRI Cymbalta. The patient has reported radiculopathy symptoms but no diagnoses of neuropathic pain. Therefore criteria as set forth by the California MTUS as outlined above have not been met and the request is not medically necessary.

Ondansetron 4mg #20: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (Moore, 2005)

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

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested medication. Per the Official Disability Guidelines section on Ondansetron, the medication is indicated for the treatment of nausea and vomiting associated with chemotherapy, radiation therapy or post-operatively. The medication is not indicated for the treatment of nausea and vomiting associated with chronic opioid use. The patient does not have a malignancy diagnosis. There is also no indication that the patient has failed more traditional first line medication such as Promethazine or Compazine. For these reasons the request is not medically necessary.