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| <b>Case Number:</b>   | CM14-0201195 |                              |            |
| <b>Date Assigned:</b> | 12/11/2014   | <b>Date of Injury:</b>       | 05/18/2001 |
| <b>Decision Date:</b> | 01/31/2015   | <b>UR Denial Date:</b>       | 11/19/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/01/2014 |

### 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 Anesthesiology, has a subspecialty in Acupuncture & Pain 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:

60y/o female injured worker with date of injury 5/18/01 with related neck and left forearm pain. Per progress report dated 12/4/14, the injured worker reported continued pain located in the left neck, shoulder, forearm, and down to her left thumb. She reported that she got a headache if she moved her arms too much. Her pain increased when she drove or wrote. She rated her pain without medication 8-9/10 and 6-7/10 with. Per physical exam, there was tenderness and spasm with palpation over the cervical spine and bilateral trapezius muscles. Positive Spurling's test was noted. There was dysesthesia along the anterior left forearm and left 1st and 2nd digits, as well as over the medial border of the left scapula. The documentation submitted for review did not state whether physical therapy was utilized. Treatment to date has included medication management. The date of UR decision was 11/19/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm Patches:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lidocaine Patch

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines p112 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. The medical records submitted for review do not indicate that there has been a trial of first-line therapy (tri-cyclic or SNRI antidepressants or an AED). There is also no diagnosis of diabetic neuropathy or post-herpetic neuralgia. As such, Lidoderm is not recommended at this time. The request is not medically necessary.

**Paroxetine 10mg #30 with three refills:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness, Stress Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Antidepressants.

**Decision rationale:** Recommended, although not generally as a stand-alone treatment. Antidepressants have been found to be useful in treating depression (Furukawa, 2002) (Joffe, 1996), including depression in physically ill patients (Gill, 1999), as well as chronic headaches associated with depression (Tomkins, 2001) (Holroy-JAMA, 2001), although one meta-analysis of trials that tested antidepressants versus placebos determined that the differences between antidepressants and placebos were small, especially when active placebos were used, thereby making the patient believe that a true antidepressant was administered through active side effects. The documentation submitted for review indicates that the injured worker has stable pain-induced depression. The request is medically necessary.

**Flexeril 10mg #30 with three refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Muscle Relaxants

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

**Decision rationale:** With regard to muscle relaxants, the MTUS CPMTG states: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may

be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement." Regarding Cyclobenzaprine: "Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants (e.g. amitriptyline). Cyclobenzaprine is more effective than placebo in the management of back pain, although the effect is modest and comes at the price of adverse effects." The documentation submitted for review indicates that the injured worker has been using this medication since as early as 6/2014. As it is only recommended for short-term use, the request is not medically necessary.

**Prilosec 10mg #30 with three refills: 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), NSAIDs, GI Symptoms & Cardiovascular Risk

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, & Cardiovascular Risk Page(s): 68.

**Decision rationale:** In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an H2-receptor antagonist or a PPI. The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). CPMTG guidelines further specify: "Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease : (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)" As there is no documentation of peptic ulcer, GI bleeding or perforation, or cardiovascular disease in the records available for my review, the injured worker's risk for gastrointestinal events is low, as such, the request is not medically necessary.