

Case Number:	CM14-0211315		
Date Assigned:	12/24/2014	Date of Injury:	10/23/2006
Decision Date:	02/17/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	12/17/2014

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 Practice, 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 54 year-old man who was injured at work on 10/23/2006. The injury was primarily to his back and right hand. He is requesting review of denial for the following medications: Lidoderm Patch; Soma; and Omeprazole. Medical records are available for review. The patient's chronic diagnoses include the following: Chronic Intractable Low Back Pain Secondary to Lumbosacral Degenerative Disc Disease; Persistent Right Hand Pain/Status Post Carpal Tunnel Release; Failed Back Syndrome; Status Post Lumbar Surgeries; Anxiety; Depression; and Chronic Pain Syndrome. The records indicate that the requested medications have been used chronically as means to address his chronic pain. He has also been seeing a psychiatrist in order to address ongoing problems with anxiety and depression. In the Utilization Review Process, the MTUS/Chronic Pain Medical Treatment Guidelines were cited in assessing each of the requested medications. Non-certification for each of the requested medications was based on the following: For Lidoderm; the provider stated Lidoderm was prescribed for muscle spasm. This is not an accepted indication for Lidoderm. For Soma; Soma is not recommended based on MTUS guidelines. Further, the patient has a history of addiction, which is well-recognized with the use of Soma. For Omeprazole; it appears that the patient is not on an NSAID. Further, the use of omeprazole was to address adverse gastrointestinal side effects from opioids. This use of omeprazole is not consistent with MTUS recommendations.

IMR ISSUES, DECISIONS AND RATIONALES

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

Topical Lidoderm patch , 1 patch 12 hours on 12 hours off: Upheld

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

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

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of Lidoderm as a treatment modality. The guidelines state the following: Lidoderm (lidocaine patch) Lidoderm is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. Topical lidocaine may be 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). 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. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and antipruritics. In this case the medical records indicate that the patient is using a Lidoderm patch for muscle spasm. This is not a recommended indication for Lidoderm. There is no evidence that the patient has a neuropathic disorder. Further, there is insufficient evidence that the efficacy of Lidoderm has been monitored for its impact on functional improvement and pain control. For these reasons, Lidoderm Patch is not considered as medically necessary.

Soma: Upheld

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

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

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of Carisoprodol (otherwise known as Soma) as a treatment modality. These guidelines state the following: Carisoprodol (Soma) not recommended. 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"). There was a 300% increase in numbers of emergency room episodes related to Carisoprodol from 1994 to 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. In this case, per the MTUS Guidelines, there is no rationale for the ongoing use of Carisoprodol/Soma. Soma is not considered as a medically necessary treatment.

Omeprazole: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs and Gastrointestinal Symptoms Page(s): 68-69.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of proton pump inhibitors (PPIs) such as Omeprazole. PPIs are typically used in patients who are on an NSAID. The guidelines state the following: NSAIDs, GI Symptoms & Cardiovascular Risk, recommend with precautions as indicated below. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (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). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDs to develop gastroduodenal lesions. 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 (200 g 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 cardio protection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxen plus low-dose aspirin plus a PPI. In this case, there is no evidence that the patient is on an NSAID. Further, there is no documentation that the patient has any of the above stated risk factors for an adverse gastrointestinal event. Finally, the evidence from the records suggests that Omeprazole is being used for adverse gastrointestinal effects of opioids; this is not consistent with the cited MTUS recommendations. For these reasons, Omeprazole is not considered as a medically necessary treatment.