

Case Number:	CM15-0011962		
Date Assigned:	01/29/2015	Date of Injury:	08/17/1999
Decision Date:	04/01/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/20/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York
 Certification(s)/Specialty: Internal Medicine

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 51-year-old male, who sustained an industrial injury on 8/17/1999. The diagnoses have included postlaminectomy syndrome, lumbar region, lumbago, lumbar radicular pain, fibromyalgia, bilateral groin pain, weight gain and constipation. Treatment to date has included spinal cord stimulator and pain medications. According to the progress note dated 12/4/2014, the injured worker had complaints of low back and left leg pain. He reported that his pain medication was adequate. He denied any side effects. He was noted to be compliant with the controlled substances agreement. The physician plan was to continue medications. The Request for Authorization of 12/23/2014 included Norco, Lunesta, Topamax, Benadryl, Voltaren Gel, Lidoderm Patch, Amitriptyline, Restoril, Cymbalta, Metamucil Powder, Prevacid and Colace. On 12/31/2014, Utilization Review (UR) non-certified a request for Lidoderm Patch 5%, citing MTUS guidelines. UR non-certified a request for Voltaren Gel citing MTUS guidelines. UR non-certified a request for Amitriptyline HCL 50mg citing MTUS guidelines. UR non-certified a request for Restoril 30mg citing MTUS guidelines. UR modified a request for Metamucil Powder citing MTUS guidelines. UR modified a request for Norco Tablets, citing MTUS and ODG guidelines. UR non-certified a request for Lunesta citing MTUS and ODG guidelines. UR non-certified a request for Pantoprazole citing MTUS guidelines. UR non-certified a request for Diphenhydramine HCL 50mg citing MTUS guidelines, ODG guidelines and other clinical protocol. UR modified a request for Colace 100mg citing MTUS guidelines. UR non-certified a request for Topamax tablets 100mg citing MTUS guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm (Lidocaine Patch 5%) x30: Upheld

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

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

Decision rationale: MTUS states that Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy, including tri-cyclic or SNRI antidepressants or an anti-epileptic drug. Per guidelines, further research is needed to recommend Lidoderm for the treatment of chronic neuropathic pain disorders other than post-herpetic neuralgia. Documentation fails to show that the injured worker's condition meets criteria for using Lidoderm. The request for Lidoderm (Lidocaine Patch 5%) x30 is not medically necessary by MTUS.

Voltaren Gel (Diclofenac Sodium Topical Gel) 1%: Upheld

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

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

Decision rationale: Voltaren Gel 1% (Diclofenac) is a topical non-steroidal anti-inflammatory drug (NSAID) indicated for short-term treatment (4-12 weeks) of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). Per MTUS, topical NSAIDs are not recommended for neuropathic pain. The injured worker is treated for chronic radicular low back and bilateral groin pain. The request for Voltaren Gel (Diclofenac Sodium Topical Gel) 1% is not medically necessary by MTUS.

Amitriptyline HCL 50mg: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tricyclic Antidepressants Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13 - 16.

Decision rationale: MTUS states that antidepressants, particularly Tricyclic antidepressants, are recommended as first-line treatment for neuropathic pain. This class of medications works in both patients with normal mood and patients with depressed mood when used in treatment for neuropathic pain, but long-term effectiveness has not been established. Documentation indicates

that the injured worker is being treated for chronic of radicular low back pain with adequate control of symptoms. The request for continued use of Amitriptyline 50mg is appropriate and medically necessary.

Restoril 30mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Treatment Index.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Per MTUS, Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Their use should be limited to 4 weeks. Documentation fails to provide details regarding any Sleep disorder that would justify the continued use of Restoril. The request for continued use of Restoril 30mg is not medically necessary by MTUS.

Metamucil, Powder, Org Sugar: Overturned

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 Not addressed. Decision based on Non-MTUS Citation <http://www.nlm.nih.gov/medlineplus/druginfo>.

Decision rationale: Metamucil (Psyllium) is a bulk-forming laxative used to treat constipation. The injured worker is diagnosed with constipation and is prescribed narcotics, which may also cause constipation. The use of Metamucil in this setting is appropriate. The request for Metamucil, Powder, Org Sugar is appropriate and medically necessary.

Norco Tablets: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74 - 82.

Decision rationale: MTUS states that opioids are not generally recommended as a first-line therapy for some neuropathic pain. When prescribed, ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects must be documented. Assessment for the likelihood that the patient could be weaned from opioids is recommended if there is no improvement in pain and function. Documentation indicates that the injured worker reports adequate pain control with no side effects, and is noted to be compliant with the

controlled substances agreement. The request for Norco Tablets is medically necessary by MTUS.

Lunesta (Eszopiclone) CIV: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Treatment Index, 12th Edition. Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lunesta (Eszopiclone).

Decision rationale: Per guidelines, hypnotics are not recommended for long-term use and should be limited to three weeks maximum in the first two months of injury only. Per guidelines, use in the chronic phase is discouraged. They are said to be habit-forming, and they may impair function and memory more than opioid pain relievers. Their use should be limited to 4 weeks. Documentation fails to provide details regarding any Sleep disorder that would justify the continued use of Lunesta. The request for Lunesta (Eszopiclone) CIV is not medically necessary.

Lansoprazole: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, treatment Index, Pain - Insomnia Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: MTUS recommends the combination of Non-steroidal anti-inflammatory drugs (NSAIDs) and Proton Pump Inhibitors (PPIs) for patients at risk for gastrointestinal events including age over 65 years of age, history of peptic ulcer, gastrointestinal bleeding or perforation, concurrent use of ASA and high dose or multiple NSAID (e.g., NSAID + low-dose ASA). Documentation does not support that the injured worker is at high risk of gastrointestinal events to justify medical necessity of Lansoprazole. The request for Lansoprazole is not medically necessary by MTUS guidelines.

Diphenhydramine Hcl 50mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA approved labeling.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation <http://www.nlm.nih.gov/medlineplus/druginfo>.

Decision rationale: Diphenhydramine is an anti-histamine that may be used to treat insomnia. Documentation fails to provide details regarding any medical condition that would justify the use of Diphenhydramine. The request for continued use of Diphenhydramine Hcl 50mg is not medically necessary.

Colace 100mg Capsules 10's: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation <http://www.nlm.nih.gov/medlineplus/druginfo>.

Decision rationale: Stool softeners are used on a short-term basis to relieve constipation by people who should avoid straining during bowel movements because of heart conditions, hemorrhoids, and other problems. The injured worker is diagnosed with constipation and chronic low back and groin pain, which could worsen if there is a need to strain. The request for continued use of Colace 100mg Capsules 10's is appropriate and medically necessary.

Topamax Tablets, 100mg 60s, TR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Medications Page(s): 21.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16.

Decision rationale: MTUS states that Anti-epilepsy drugs (AEDs) are recommended for neuropathic pain (pain due to nerve damage) associated with post-herpetic neuralgia and diabetic painful polyneuropathy. There are few randomized controlled trials (RCTs) directed at central pain and none for painful radiculopathy. Topiramate (Topamax) has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. The injured worker is treated for chronic radicular low back and bilateral groin pain. The request for continued use of Topamax Tablets, 100mg 60s, is not medically necessary by MTUS guidelines.