

<b>Case Number:</b>	CM15-0194711		
<b>Date Assigned:</b>	10/08/2015	<b>Date of Injury:</b>	09/05/2005
<b>Decision Date:</b>	12/16/2015	<b>UR Denial Date:</b>	09/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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 57 year old female who sustained an industrial injury September 05, 2005. An encounter dated May 12, 2015 reported subjective complaint of "significant difficulty with her pain and coping with ADLs as a result." She states having difficulty getting medications due to denials for OxyContin and Norco and she paid out of pocket for Norco. She continues with "chronic neck pain and upper extremity pain." The pain is noted localized to her neck, shoulders, elbows, wrists, and hands. She reports frequent spasm of neck and shoulders. She did undergo repeat left shoulder surgery on October 2009. Current medication regimen consisted of: OxyContin, Norco, Flexeril, Pepcid, Zolofit and Neurontin. She states that "her medications are currently only reducing her pain by about 40%." The assessment noted: status post left trigger finger thumb release, status post debridement of right TFCC and ulnar lunate joint; status post right ulnar osteotomy; status post left dorsoradial carpal ganglionectomy; status post bilateral carpal tunnel releases; survival strain, cervicgia, pain related insomnia, and depression; early trigger finger of the third left digit; bilateral lateral epicondylitis; and bilateral shoulder impingement syndrome, status post right subacromial decompression. The plan of care is noted: discontinuing OxyContin and Norco and instead prescribe Oxycodone and continue on the remainder of medications. Primary follow up dated January 28, 2015 reported multiple denials of medications involving: Flexeril, Lidocaine Priolocaine cream, Lidoderm patches, Norco, OxyContin also with out of pocket payments. Lidoderm patches noted discontinued and she still continues paying out of pocket for Lidocaine Priolocaine cream, Flexeril and Pepcid. On August 20, 2015 a request was made for Eszopiclone, Famotidine, and Gabapentin, Sertraline, and Lidocaine Priolocaine cream that were noncertified on September 01, 2015 by Utilization Review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Eszopiclone 1mg #30 D/S with 1 refill: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Benzodiazepines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-Pain Chapter- (Chronic): Eszopiclone (Lunesta); Insomnia treatment.

**Decision rationale:** The California Medical Treatment Utilization Schedule (CMTUS) guidelines are silent on this request. According to the ODG guidelines, Eszopiclone (Lunesta) is a prescription short-acting non-benzodiazepine sedative-hypnotic, which is recommended for short-term treatment of insomnia (two to six weeks). Benzodiazepine-receptor agonists work by selectively binding to type-1 benzodiazepine receptors in the CNS. Lunesta is indicated for the treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Non-Benzodiazepine sedative-hypnotics are considered first-line medications for insomnia. All of the benzodiazepine-receptor agonists are schedule IV controlled substances, which have potential for abuse and dependency. There is lack of documentation of symptoms of insomnia and the resulting impairments. In this case, there is no documentation of the use of sleep hygiene techniques being used to correct sleep deficits. Therefore, the request for Eszopiclone 1mg #30 D/S with 1 refill is not medically necessary.

**Famotidine 20mg #30 with 3 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** Famotidine is an H2 antagonist for gastrointestinal (GI) protection. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. In this injured worker, there is no documentation of any reported GI complaints. Based on the available information provided for review, the medical necessity for Omeprazole has not been established. The requested treatment : Famotidine 20mg #30 with 3 refills is not medically necessary.

**Gabapentin 300mg #120 with 1 refill: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--Gabapentin (Neurontin).

**Decision rationale:** According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. The records documented that this injured worker has chronic pain. Neurontin has been part of her medical regimen. There is no compelling evidence presented by the treating provider that indicates this injured worker, had any significant improvements from use of this medication. Also review of Medical Records do not indicate that in this injured worker, previous use of this medication, has been effective in maintaining any measurable objective evidence of functional improvement. The requested treatment: Gabapentin 300mg #120 with 1 refill is not medically necessary.

**Sertraline HCL 100mg #30 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): SSRIs (selective serotonin reuptake inhibitors).

**Decision rationale:** As per MTUS Sertraline is not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. Selective serotonin reuptake inhibitors (SSRIs), a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline, are controversial based on controlled trials. It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. There is no compelling evidence presented by the treating provider that indicates this injured worker has had any significant improvements from this medication, and also review of Medical Records do not clarify that previous use of this medication has been effective in this injured worker for maintaining any functional improvement. Based on the currently available information, the medical necessity for this requested item has not been established. The requested treatment is not medically necessary.

**Lidocaine-Prilocaine 2.5% #90 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics, such as the Lidocaine, are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control, for example, NSAIDs, opioids or antidepressants. 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. There is no documentation that the injured worker has failed a trial of antidepressants and anticonvulsants and is intolerant to other medicines. Review of Medical Records do not indicate that previous use of this medication in this injured worker has been effective in maintaining any measurable functional improvement. Medical necessity of the requested treatment: Lidocaine-Prilocaine 2.5% #90 with 1 refill has not been established.