

Case Number:	CM15-0202276		
Date Assigned:	10/19/2015	Date of Injury:	08/02/2002
Decision Date:	12/21/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	10/14/2015

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: Anesthesiology

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 44 year old female, who sustained an industrial injury on 08-02-2002. The injured worker is currently working fulltime. Medical records indicated that the injured worker is undergoing treatment for lumbar disc degeneration, right hip labral tear, mood disorder, and sacroiliac pain. Treatment and diagnostics to date has included physical therapy, home exercise program, and medications. Recent medications have included Omeprazole, Oxycodone, OxyContin, Trazodone, and Gabapentin. Subjective data (07-06-2015 and 08-03-2015), included lower backache rated 7 out of 10 with medications and 10 out of 10 without medications. Objective findings (08-03-2015) included an antalgic gait, tenderness to palpation to lumbar spine, right sacroiliac joint, left shoulder, right hip, and bilateral knees, and restricted range of motion to right hip and right knee. The request for authorization dated 08-03-2015 requested Lidoderm 5% patch-1 daily #30, Oxycodone 30mg-take 1 every 4-6 hours #120, OxyContin 80mg-1 three time a day #90, Trazodone 150mg-take 1 at bedtime #30, Gabapentin 300mg-take 1 four times a day #120, and Omeprazole 20mg-take 1 twice daily #60. The Utilization Review with a decision date of 09-14-2015 non-certified the request for Lidoderm patch 5% #30, Oxycodone 30mg #120, OxyContin 60mg #90, Trazodone 150mg #30, Gabapentin 300mg #120, and Omeprazole 20mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm Patch 5% Qty 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: According to the California MTUS Guidelines, topical analgesics, such as Lidoderm patches, 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. Lidoderm is the brand name for a lidocaine patch. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants, or an AED, such as gabapentin or Lyrica). Lidoderm patches are not a first-line treatment and are 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. In addition, this medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. Lidoderm patches have been prescribed for over a year with no objective evidence of any functional improvement. Medical necessity of the requested medication has not been established. The requested topical analgesic is not medically necessary.

Oxycodone 30mg Qty 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, specific drug list.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the ODG and MTUS, Oxycodone (Oxy-IR, immediate-release) is a short-acting opioid analgesic. Opioid drugs are available in various dosage forms and strengths. According to the ODG, chronic pain can have a mixed physiologic etiology of both that may be used to manage both acute and chronic pain. These medications are generally classified according to potency and duration of dosage. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. There was no documentation of the medication's pain relief effectiveness, functional

improvement from previous usage, or response to ongoing opiate therapy. Medical necessity of the requested opioid analgesic was not established. Of note, discontinuation of an Oxycodone should include a taper, to avoid withdrawal symptoms. The requested Oxycodone was not medically necessary.

Oxycontin 60mg Qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, specific drug list.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the MTUS and ODG, OxyContin is the brand name of a time-release formula of the analgesic chemical oxycodone. Oxycodone controlled-release (OxyContin) is a long-acting opioid analgesic. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." In this case, there is insufficient evidence that the opioids were prescribed according to the CA MTUS guidelines, which recommend prescribing according to function, with specific functional goals, return to work, random drug testing, an opioid contract, and documentation of a prior failure of non-opioid therapy. There was a lack of functional improvement with the treatment already provided. Medical necessity of the requested opioid analgesic has not been established. Of note, discontinuation of an opioid should include a taper, to avoid withdrawal symptoms. The requested Oxycontin is not medically necessary.

Trazodone 150mg Qty 30: Upheld

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

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

Decision rationale: According to the ODG, Trazodone (Desyrel) is a sedative hypnotic. It is not recommended for long-term use but is recommended for short-term use. It is discouraged in the chronic phase of injury and pain. Trazodone (Desyrel) is recommended as an option for insomnia, only for patients with potentially co-existing mild psychiatric symptoms such as depression or anxiety. It is unrelated to tricyclic or tetracyclic antidepressants and has some action as an anxiolytic. This can be habit-forming, and may impair function and memory more than opioid pain relievers. There is also concern that it may increase pain and depression over the long-term. In this study, receiving hypnotic prescriptions was associated with greater than a

threefold increased hazard of death even when prescribed less than 18 pills/year. In this case, there is no documentation indicating that this medication has been proven to be beneficial for the treatment of her condition. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Gabapentin 300mg Qty 120: 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) Gabapentin (Neurontin).

Decision rationale: According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. The records documented that the patient has neuropathic pain related to his chronic low back condition. In this case, there was no documentation of subjective or objective findings consistent with current neuropathic pain to necessitate use of Neurontin. Medical necessity for Neurontin has not been established. The requested medication is not medically necessary.

Omeprazole 20mg Qty 60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to the CA MTUS, proton pump inhibitors, such as Omeprazole (Prilosec), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. 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 case, there is documentation indicating the patient has had GI symptoms. This patient has been taking Celebrex. Medical necessity for Omeprazole has been established, while this patient is on NSAIDs, such as Celebrex. The requested medication is medically necessary.