

Case Number:	CM15-0038517		
Date Assigned:	03/09/2015	Date of Injury:	12/04/2001
Decision Date:	05/01/2015	UR Denial Date:	02/10/2015
Priority:	Standard	Application Received:	03/02/2015

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 39-year-old female, who sustained an industrial injury on 12/4/01. She has reported pain in the lower back related to a fall. The diagnoses have included lumbago, depression, chronic pain syndrome, and myofascial pain. Treatment to date has included lumbar MRI, joint injections, physical therapy, TENs unit, psychiatric treatments and pain medications. As of the PR2 dated 1/12/15, the injured worker reports pain in the low back, sacral area and hips related to being out of Oxycodone for 10 days. She indicated that her pain and mood are stable on the current medications. The treating physician requested to continue Robaxin 750mg #240 x 5 refills, Diazepam 5mg #40 x 4 refills, Cymbalta 60mg #30 x 5 refill, Lidoderm patches 5%, Geodon 80mg #30 x 5 refills and Voltaren 1% gel. On 2/10/15 Utilization Review non-certified a request for Robaxin 750mg #240 x 5 refills, Lidoderm patches 5% and Voltaren 1% gel and modified a request for Diazepam 5mg #40 x 4 refills to Diazepam 5mg #40 x 0 refills, Cymbalta 60mg #30 x 5 refills to Cymbalta 60mg #30 x 1 refill and Geodon 80mg #30 x 5 refills to Geodon 80mg #30 x 1 refill. On 2/27/15, the injured worker submitted an application for IMR for review of Robaxin 750mg #240 x 5 refills, Diazepam 5mg #40 x 4 refills, Cymbalta 60mg #30 x 5 refills, Lidoderm patches 5%, Geodon 80mg #30 x 5 refills and Voltaren 1% gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Robaxin 750mg #240 with 5 refills: Upheld

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

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

Decision rationale: Robaxin (Methocarbamol) is an antispasmodic muscle relaxant. The mechanism of action is unknown, but appears to be related to central nervous system depressant effects with related sedative properties. According to CA MTUS Guidelines, muscle relaxants are not recommended for the long-term treatment of chronic pain. They are not recommended to be used for longer than 2-3 weeks. There is no documentation of functional improvement from any previous use of this medication. According to the guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

Diazepam 5mg #40 with 4 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Benzodiazepines.

Decision rationale: According to CA MTUS Guidelines, benzodiazepines are prescribed for anxiety. They are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Valium (Diazepam) is a long-acting benzodiazepine, having anxiolytic, sedative, and hypnotic properties. Most guidelines recommend the use of Valium for the treatment of anxiety disorders, and as an adjunct treatment for anxiety associated with major depression. Use of this medication is limited to four weeks. In addition, there are no guideline criteria that support the long-term use of benzodiazepines. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Cymbalta 60mg #30 with 5 refills: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants: SNRIs Page(s): 13, 15-16.

Decision rationale: According to the California MTUS Guidelines, antidepressants are indicated for the treatment of chronic pain. They are recommended as a first-line option for neuropathic pain, and as a possibility for non-neuropathic pain. The documentation indicates the patient has depression, anxiety and bipolar affective disease. Per the documentation, the use of Cymbalta in this patient's medical regimen has proven beneficial with reported decreased depression, decreased pain levels, and increased function. Medical necessity for the requested medication has been established. The requested medication is medically necessary.

Lidoderm patches 5%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Topical analgesics.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics, such as the Lidoderm 5% Patch, 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 (tri-cyclic 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 this case, medical necessity of the requested item has not been established. The certification of the requested Lidoderm patches are not recommended or medically necessary.

Geodon 80mg #30 with 5 refills: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 388 & 402.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal medicine 2014- Geodon.

Decision rationale: Ziprasidone (Geodon) is an atypical antipsychotic. It is approved by the FDA for the treatment of schizophrenia, acute mania, and mixed states associated with bipolar disorder. The documentation indicates the patient has depression, anxiety, and bipolar affective disorder. This medication is part of her medical regimen and she is to undergo an evaluation by a psychiatrist. Medical necessity for the requested item is established. The requested item is medically necessary.

Voltaren 1% gel: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Topical analgesics.

Decision rationale: The California MTUS Guidelines state Voltaren gel 1% (diclofenac) has an FDA appropriation indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment, such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip, or shoulder. The submitted documentation does not indicate that the injured worker had a diagnosis of osteoarthritis. Additionally, the efficacy of the medication was not submitted for review, nor was it indicated that it helped with any functional deficits the injured worker had. Medical necessity for the requested topical agent has not been established. The requested medication is not medically necessary.