

Case Number:	CM15-0050387		
Date Assigned:	03/23/2015	Date of Injury:	01/06/1998
Decision Date:	06/02/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/17/2015

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 67 year old female who sustained an industrial injury on 1/6/98. She has reported initial complaints of neck injury with pain. The diagnoses have included chronic pain, cervical degenerative /lumbosacral intervertebral disc disease, thoracic neuritis, radiculitis, cervicgia, fibromyalgia, myalgia and myositis and gastritis. Treatment to date has included medications, surgery, diagnostics, physical therapy and activity modifications. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the lumbar spine, Magnetic Resonance Imaging (MRI) of the right shoulder, computerized axial tomography (CT scan) scan of the cervical spine and computerized axial tomography (CT scan) myelogram. Currently, as per the physician progress note dated 2/13/15, the injured worker complains of neck pain with arm pain to the left, headaches, back spasm, bilateral hip pain, burning feet pain, and muscle spasm. She reported that she is seeing a spinal surgeon. The physical exam revealed chronic low back pain with bilateral leg pain, bilateral extremity pain, poor sleep, depression and anxiety, myofascial pain/spasm with trigger points, generalized deconditioning, weight gain, and left shoulder pain related to partial rotator cuff tear and status post repair. The physician noted that the medications have been beneficial with decreasing the pain. The physician requested treatments included Metanx #180 for 2 months Rx dates: 02/09/15 and 03/09/15, Lidoderm 5% patches (700mg/patch) #90 for 2 months Rx dates: 02/09/15 and 03/09/15, Savella 12.5mg #60 for 2 months Rx dates: 02/09/5 and 03/09/15 and Abstral 300mcg #32 for 2 months Rx dates: 02/09/15 and 03/09/15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Metanx #180 for 2 months Rx dates: 02/09/15 and 03/09/15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Procedure summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Wikipedia.

Decision rationale: Metanx is a prescription medical food that contains Metafolin (calcium salt of vitamin B9), vitamin B12, and vitamin B6. It is a vitamin B supplement and is indicated for the dietary management of peripheral neuropathy. In this case, the patient has had chronic pain dating back to 1998. There is no documentation of effectiveness or functional improvement with the use of this medical food. Medical necessity for the requested medical food was not established. The requested medical food is not medically necessary.

Lidoderm 5% patches (700mg/patch) #90 for 2 months Rx dates: 02/09/15 and 03/09/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain procedure summary.

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. Medical necessity of the requested 5% Lidoderm patches has not been established. The requested Lidoderm patches are not medically necessary.

Savella 12.5mg #60 for 2 months Rx dates: 02/09/15 and 03/09/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain procedure summary.

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

Decision rationale: Milnacipran (Savella) is a serotonin-norepinephrine reuptake inhibitor (SNRI) used in the clinical treatment of fibromyalgia. According to the ODG, SNRIs are recommended as an option in first-line treatment of neuropathic pain, especially if tricyclics are ineffective, poorly tolerated, or contraindicated. Savella is FDA approved, but under study for the treatment of fibromyalgia. In this case, the patient had prior use of Savella without any documentation of significant improvement. In this case, there was no documentation of objective benefit from use of this medication. There is no documentation of functional improvement from any previous use of this medication. Medical necessity of the requested medication has not been established. The request for Savella is not medically necessary.

Abstral 300mcg #32 for 2 months Rx dates: 02/09/15 and 03/09/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid analgesic. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain procedure summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Fentanyl Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fentanyl, Abstral (fentanyl transmucosal).

Decision rationale: Abstral (fentanyl transmucosal) is a formulation of Fentanyl citrate available as a sublingual tablet. It is used to treat breakthrough cancer pain that is not controlled by other medications. According to the CA MTUS and the ODG, Fentanyl is a long-acting narcotic analgesic. It is an opioid analgesic with a potency of eighty times that of Morphine. According to the ODG, chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added. Abstral is an FDA approved immediate-release transmucosal tablet formulation of Fentanyl for the management of breakthrough cancer pain. Because Abstral is subject to abuse and misuse, the product was approved with a risk evaluation and mitigation strategy (REMS) that includes a restricted distribution program requiring registration of prescribers, pharmacies, and patients. It is not recommended as a first-line agent for musculoskeletal pain. This patient has been maintained on long-acting and short-acting opioids, including Percocet. In this case, there is no evidence of cancer pain. Medical necessity for the requested medication has not been established. Abstral is not medically necessary.