

Case Number:	CM15-0050845		
Date Assigned:	03/24/2015	Date of Injury:	02/26/1990
Decision Date:	05/13/2015	UR Denial Date:	03/03/2015
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:

This 49 year old woman sustained an industrial injury on 2/26/1990. The mechanism of injury is not detailed. Diagnoses include right wrist injury with five corrective surgical procedures and complex regional pain syndrome. Treatment has included oral medications, surgical intervention, and finger splints. Physician notes on a PR-2 dated 2/12/2015 show complaints of right hand pain with radiation to the upper extremity and intermittent left upper extremity pain. Recommendations include psychological consultation for spinal cord stimulator trial, continue current medication regimen including Stadol, Celebrex, Lyrica, Restoril, Lidoderm, Doxepin, and Ultram, and follow up in one month.

IMR ISSUES, DECISIONS AND RATIONALES

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

Restoril 30mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Page(s): 24.

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

Decision rationale: Restoril (Temazepam) is an intermediate-acting 3-hydroxy hypnotic of the benzodiazepine class of psychoactive drugs. It is approved for the short-term treatment of insomnia. 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. There is no documentation provided indicating that the patient has a diagnosis of insomnia or indicating the duration of therapy with this medication. 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.

Stadol NS 10mg /MI #20: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.ncbi.nlm.nih.gov/pubmed/7650235>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: Stadol (Butorphanol) is a morphine-type synthetic opioid used for the treatment of migraines, using the intranasal spray formulation, and for the treatment of moderate to severe pain. According to the CA MTUS and the ODG, 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 no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opiate therapy. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-94, 78-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the treatment of chronic pain Page(s): 91-97.

Decision rationale: According to the California MTUS, Tramadol (Ultram) is a synthetic opioid, which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's

analgesic effectiveness or functional improvement, and no clear documentation that the patient has responded to ongoing opioid therapy. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Refill of Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-94, 78-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97.

Decision rationale: Medical necessity of the requested Tramadol ER was not established. The requested medication was not to be medically necessary. Therefore, the refill of Tramadol ER is not medically necessary.

Lidoderm 5% #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111-113, 56-57.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics, such as the 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. In addition, this medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. In this case, the patient is currently maintained on the antiseizure medication, Lyrica. Medical necessity of the requested 5% Lidoderm patches has not been established. The requested Lidoderm patches are not medically necessary. Therefore, the refill of Lidoderm patches is not medically necessary.

Refill of Lidoderm 5% #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113, 56-57.

Decision rationale: Medical necessity of the requested 5% Lidoderm patches was not established. The requested Lidoderm patches were not found to be medically necessary. Therefore, the refill of Lidoderm patches is not medically necessary.

Refill of Lidoderm 5% #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113, 56-57.

Decision rationale: Medical necessity of the requested 5% Lidoderm patches was not established. The requested Lidoderm patches were not found to be medically necessary. Therefore, the refill of Lidoderm patches is not medically necessary.

Refill of Lidoderm 5% #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113, 56-57.

Decision rationale: Medical necessity of the requested 5% Lidoderm patches was not established. The requested Lidoderm patches were not found to be medically necessary. Therefore, the refill of Lidoderm patches is not medically necessary.