MAXIMUS Federal Services

Case Number:	CM15-0058270		
Date Assigned:	04/28/2015	Date of Injury:	06/08/1996
Decision Date:	06/12/2015	UR Denial Date:	02/19/2015
Priority:	Standard	Application Received:	03/26/2015

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 male who sustained an industrial injury on 6/8/96. The diagnoses have included chronic pain syndrome, carpel tunnel syndrome, and cervical disc displacement without myelopathy, cervical intervertebral disc degeneration, lumbar degenerative disc disease (DDD), cervical spinal stenosis, insomnia, depression and cervicalgia. Treatment to date has included medications, activity modifications, diagnostics, and injections. The diagnostic testing that was performed included electromyography (EMG) of the upper extremities. Currently, as per the physician progress note dated 1/30/15, the injured worker complains of cervical pain. Physical exam revealed cervical movement was moderately restricted in all directions with pain, left and right upper extremity strength was decreased, and reflexes were hyporeflexic on the lower extremities. The plan was to increase ability to self -manage pain and related problems and return to productive activities at home and work with use of medications. There was no urine drug screen noted. The physician requested treatments included 1 Prescription for Ambien 10mg #30 with 1 refill, 1 Prescription for Robaxin 750mg #90 with 1 refill, 1 Prescription for Flector Patch 1.3% #60 with 1 refill, 1 Prescription for Prilosec 20mg #30 with 1 refill and 1 Prescription for Lidoderm 5% with 1 refill.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription for Ambien 10mg #30 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Insomnia.

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

Decision rationale: Zolpidem (Ambien) is a prescription short-acting non-benzodiazepine hypnotic, which is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Ambien can be habit-forming, and may impair function and memory more than opioid analgesics. There is also concern that Ambien may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology, and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case, there are no reports of difficulty with sleep or recent history of insomnia. There is no documentation provided indicating medical necessity for Ambien. The requested medication is not medically necessary.

1 Prescription for Robaxin 750mg #90 with 1 refill: Upheld

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

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

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. 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 medication, with 1 refill, is not medically necessary.

1 Prescription for Flector Patch 1.3% #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Pain, Flector Patch.

Decision rationale: According to California MTUS Guidelines, oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. ODG states that NSAIDs are recommended for acute pain, acute low back pain (LBP), short-term pain relief in chronic LBP, and short-term improvement of function in chronic LBP. There is no evidence of long-term effectiveness for pain or function. According to ODG, the use of a Flector patch (Diclofenac) is recommended for osteoarthritis after failure of an oral NSAID or contraindications to oral NSAIDs. Physicians should measure transaminases periodically in patients receiving long-term therapy with Diclofenac. This medication may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. In addition, there is no data that substantiate Flector patch efficacy beyond two weeks. There is little evidence that supports the medication use in the treatment of chronic low back pain. Medical necessity for the requested Flector patch has not been established. The requested item is not medically necessary.

1 Prescription for Prilosec 20mg #30 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID, Proton Pump Inhibitor.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to the California MTUS (2009), Omeprazole (Prilosec), is proton pump inhibitor (PPI) that is recommended for patients taking NSAIDs, with documented GI distress symptoms, or at risk for gastrointestinal events. GI risk factors include age >65, history of peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or anticoagulants, or high dose/multiple NSAIDs. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. In this case, there is no documentation indicating that this patient had any GI symptoms or risk factors. In addition, the request for Flector patches was found to be not medically necessary, which would mean that the Prilosec would not appear to be medically necessary for this patient. Medical necessity for Prilosec has not been established. The requested medication is not medically necessary.

1 Prescription for Lidoderm 5% with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. 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 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. 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. In this case, medical necessity of the requested item has not been established. Medical necessity of the requested 5% Lidoderm patches has not been established. The requested Lidoderm patches are not medically necessary.