

Case Number:	CM15-0084614		
Date Assigned:	05/08/2015	Date of Injury:	06/18/2009
Decision Date:	06/29/2015	UR Denial Date:	04/20/2015
Priority:	Standard	Application Received:	05/04/2015

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 51 year old female who sustained an industrial injury on 06/18/2009. Diagnoses include cervical disc disorder, elbow pain, shoulder pain, cervical radiculopathy, depression with anxiety, entrapment neuropathy of an upper limb, and cervical facet syndrome. Treatment to date has included diagnostic studies, medications, acupuncture, Transcutaneous Electrical Nerve Stimulation unit, physical therapy, and home exercise program. Her medications include Therma Care Heat Wraps, Gabapentin, Lidoderm Patch, Zofran, Lactulose, Miralax Powder, Tizanidine, Omeprazole, Clonazepam, Oxycodone Hcl, Topamax, Zolofit and Trazodone. A physician progress note dated 03/16/2015 documents the injured worker complains of pain in the left shoulder, left elbow, right elbow and neck. Her pain level fluctuates depending on her activity. She reports that pain occurs constantly and is piercing, and sharp. She also complains of joint pain, joint stiffness, muscle spasms, numbness tingling and weakness. She reports she takes her medications as prescribed and her medications continue to reduce her pain level with minimal side effects, and she has an improved function such as cooking, cleaning and shopping. Emotionally she is more stable and less irritable and emotionally labile than without medications. She rates her pain as 3 out of 10 with medications and 9 out of 10 without medications. It is documented there is a signed Opiate Agreement present in her electronic files. She has tenderness at the manubriosternal joint, paracervical muscle, sternoclavicular joint and trapezius on the right. She has cervical facet tenderness at C3, C4, C5, and C6. Her left shoulder range of motion is restricted. Both elbows reveal tenderness to palpation over the lateral epicondyle and medial epicondyle. Tinel's sign is positive at the

right ulnar groove and left wrist and medial epicondyle. She has a positive Phalen bilaterally. Treatment requested is for Clonazepam 0.25mg QTY: 60, Gabapentin 300mg QTY: 90 with 3 refills, Lidoderm 5% patch QTY: 60 with 3 refills, Miralax Powder Packet 17 gram QTY: 60, Omeprazole 20mg QTY: 60 with 3 refills, Oxycodone HCL 15mg QTY: 240, Therma Care Heat Wraps QTY: 60 with 3 refills, Tizanidine HCL 4mg QTY: 90 with 3 refills, Topamax 50mg QTY: 90 with 3 refills, and Zofran 8mg QTY: 60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Therma Care Heat Wraps QTY: 60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter.

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

Decision rationale: The ODG recommend the use of at-home local applications of cold packs for treatment in the first few days of acute injury followed by the application of heat. There is no specific indication for the use of heat wraps. There is no documentation of functional improvement with heat wrap therapy. Medical necessity for the requested item is not established. The requested Therma Care wraps are not medically necessary.

Zofran 8mg QTY: 60: Upheld

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

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

Decision rationale: Ondansetron (Zofran) is used to prevent nausea and vomiting that may be caused by anesthesia/surgery, or chemotherapy or radiation therapy. It is also approved for use acutely with gastroenteritis. Ondansetron is not used and is ineffective for nausea associated with narcotic analgesics. In addition, for this case, the request for Oxycodone was not medically necessary, which would also make the request for Ondansetron not medically necessary. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

Tizanidine HCL 4mg QTY: 90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63, 66.

Decision rationale: Tizanidine (Zanaflex) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and considered an adjunct treatment for fibromyalgia. According to CA MTUS Guidelines, muscle relaxants have not been considered any more effective than non-steroidal anti-inflammatory drugs (NSAIDs) for pain or overall improvement. There is no additional benefit shown in combination with NSAIDs. In addition, sedation is the most commonly reported adverse effect of muscle relaxant medications. There is no documentation of functional improvement with the use of this medication. The guideline criteria do not support the long-term (>2 wks) use of muscle relaxants. Medical necessity for the requested medication has not been established. The requested medication, Tizanidine, is not medically necessary.

Oxycodone HCL 15mg QTY: 240: Upheld

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

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

Decision rationale: According to ODG and MTUS, Oxycodone (Oxycontin) is a long-acting opioid analgesic. Opioid drugs are available in various dosage forms and strengths. They are considered the most powerful class of analgesics. 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 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 item has not been established. Of note, discontinuation of an Oxycodone should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Lidoderm 5% patch QTY: 60 with 3 refills: 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): 56-57.

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 is not recommended.

Miralax Powder Packet 17 gram QTY: 60: Upheld

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

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

Decision rationale: Miralax is in a class of medicines called osmotic laxatives. It works by causing water to be retained in the stool. This softens the stool and increases the number of bowel movements. Opioid-induced constipation is a common adverse effect of long-term opioid use because of the binding of opioids to peripheral opioid receptors in the gastrointestinal tract, resulting in absorption of electrolytes and reduction in small intestine fluid. According to ODG, if opioids are determined to be appropriate for the treatment of pain then prophylactic treatment of constipation should be initiated. In this case, with non-approval of opioid use, the medical necessity of Miralax is not established. The requested medication is not medically necessary.

Topamax 50mg QTY: 90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 17-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) AEDs.

Decision rationale: According to the CA MTUS (2009) and ODG, Topamax (Topiramate) is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. The records documented that this patient has neuropathic pain but there is no documentation of objective functional improvement with the use of this medication. Medical

necessity for Topamax has not been established. The requested medication is not medically necessary.

Gabapentin 300mg QTY: 90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epileptic drugs (AEDs) Page(s): 17-19. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) AEDs.

Decision rationale: According to the CA MTUS (2009) and the ODG, Gabapentin (Neurontin) is an anti-epilepsy drug, which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia, and has been considered as a first-line treatment for neuropathic pain. The records documented that this patient has neuropathic pain but there is no documentation of objective functional improvement with the use of this medication. Medical necessity for Gabapentin has not been established. The requested medication is not medically necessary.

Omeprazole 20mg QTY: 60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

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

Decision rationale: According to CA MTUS (2009), proton pump inhibitors, such as Omeprazole (Prilosec), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any GI symptoms or 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. There is no documentation of any reported GI complaints. Based on the available information provided for review, the medical necessity for Prilosec has not been established. The requested medication is not medically necessary.

Clonazepam 0.25mg QTY: 60: Upheld

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

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. Clonazepam (Klonopin) is a long-acting benzodiazepine, having anxiolytic, sedative, and hypnotic properties. Most guidelines recommend the use of Clonazepam 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. There are no guideline criteria that supports the long-term use of benzodiazepines. In this case, there was no documentation of the indication and duration of use. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.