

Case Number:	CM14-0133133		
Date Assigned:	08/22/2014	Date of Injury:	12/28/1992
Decision Date:	09/29/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	08/20/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 reported an injury on 12/28/1992 due to a fall. On 07/08/2014, the injured worker presented with back pain. Diagnoses were chronic pain syndrome, spinal stenosis of the lumbar region, spinal re-fusion not otherwise specified, scoliosis associated with other conditions, failed back surgery syndrome to the lumbar spine, and myalgia/myositis unspecified. Upon examination, the injured worker had back pain and muscle weakness with depression. There were 10 prior back surgeries. Current medication list included Toviaz, Levothyroxine, Benazepril/Hydrochlorothiazide, Estradiol, Zanaflex, Hydroxyzine Pamoate, OxyContin, Wellbutrin, Xenical, and Lidoderm. The provider recommended Xenical, Wellbutrin, Prochlorperazine Maleate, OxyContin, and Lidoderm. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Xenical 120 Mg, QTY: 60, Refills: 4: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation RxList, Xenical, Online Database, www.RxList.com/Xenical-drug.htm.

Decision rationale: According to scientific base research, Xenical is a gastrointestinal lipase inhibitor for obesity management that acts by inhibiting the absorption of dietary fats. It is indicated for obesity management, included weight loss and weight maintenance when used in conjunction with a reduced calorie diet. Xenical is also indicated to reduce the risks for weight regain after prior weight loss. The provider's rationale for Xenical was for constipation induced by opioids. There is no off label use for treatment of constipation. Therefore, Xenical would not be warranted. The provider's request also does not indicate the frequency of the medication in the request as submitted. As such, medical necessity has not been established.

Wellbutrin SR 150 Mg, QTY: 30, Refills: 4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13.

Decision rationale: California MTUS Guidelines recommend antidepressants as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration. Side effects including excessive sedation (especially that which would affect work performance) should be assessed. The optimal duration of treatment is not known because most double-blind trials have been of short duration between 6 to 12 weeks. There is lack of evidence of an objective assessment of the injured worker's pain level. The frequency was also not provided in the request as submitted. As such, medical necessity has not been established.

Prochlorperazine Maleate 5 Mg, QTY: 30, Refills: 2: Upheld

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

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

Decision rationale: The Official Disability Guidelines do not recommend Prochlorperazine Maleate for nausea and vomiting secondary to chronic opioid use. Nausea and vomiting is common with the use of opioids. The side effects tend to diminish over days to weeks of continued exposure. Studies of opioid adverse effects, including nausea and vomiting, are limited to short term duration and have limited application to long term use. If nausea and vomiting remain prolonged, other etiologies of these symptoms should be evaluated for. As the guidelines do not recommend Prochlorperazine Maleate for nausea and vomiting secondary to opioid use,

the medication would not be indicated. Additionally, the efficacy of the prior use of the medication was not provided. The provider's request does not indicate the frequency of the medication. As such, medical necessity has not been established.

OxyContin 20 Mg, QTY: 180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug abuse, behaviors, and side effects. Additionally, the efficacy of the prior use of the medication was not provided. The provider's request does not indicate the frequency of the medication in the request as submitted. As such, medical necessity has not been established.

Lidoderm 5% (700MG/Patch), QTY: 30, Refills: 4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine Patch) Page(s): 56-57.

Decision rationale: California MTUS states topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a first line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). This is not a first line treatment and it is only FDA approved for postherpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. There is lack of documentation that the injured worker has a diagnosis congruent with the guidelines recommendations. There is a lack of evidence of a failed trial of a first line treatment. Additionally, the efficacy of the prior use of the medication was not provided. As such, medical necessity has not been established.