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| Case Number: | CM14-0168367 | | |
| Date Assigned: | 10/16/2014 | Date of Injury: | 08/19/2011 |
| Decision Date: | 12/17/2014 | UR Denial Date: | 09/18/2014 |
| Priority: | Standard | Application Received: | 10/13/2014 |

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 California. 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:

This is a female patient with a date of injury of August 19, 2011. A utilization review determination dated September 18, 2014 recommends non-certification of Lidoderm Patches 5% #30, Lunesta 2 mg #30, Lexapro 20 mg #30, soma 350 mg #100, Esgic #50, and Voltaren cream 1% 3 boxes/10 tubes. A progress note dated September 11, 2014 identifies subjective complaints of severe migraine headaches, anxiety, restlessness, and continued increased pains with stiffness and soreness of the lower back. The physical examination reveals minimally decreased range of motion of the neck, bilateral shoulder with positive impingement signs and decreased range of motion by approximately 10%, and lower back shows 2/4 paravertebral muscle spasm. The diagnoses include frequent chronic severe lower back pains, satisfactory post-op left arm carpal tunnel release, asymptomatic left cubital tunnel syndrome, status post successful disc replacement C5-6, post-op surgery for 5 mm herniated lumbar disc at L5-S1, weight gain post-op, asymptomatic gastric ulcer disease, long left leg accentuating stream to the lower back slightly, and hypothyroidism. The treatment plan recommends that the patient see an internist regarding edema of hands, Xanax 0.5 mg #80, Esgic #54 headaches, Lexapro 20 mg #30, subscapularis exercise program Lidoderm patches 5% #30 apply to skin over painful lumbar areas, Nexium, Soma #100, Lunesta 2 mg #30, and resume Voltaren cream three boxes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patches 5% #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112 of 127.

Decision rationale: Regarding request for Lidoderm Patches 5% #30, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Additionally, there is no documentation of analgesic effect or objective functional improvement as a result of the currently prescribed Lidoderm. Finally, there is no indication that the Lidoderm is to be used for localized peripheral pain as recommended by guidelines. As such, the currently requested Lidoderm Patches 5% #30 is not medically necessary.

Lunesta 2mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Med Lett Drugs Ther. 2005 Feb 28;47(1203):17-9, Eszopiclone (Lunesta)

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

Decision rationale: Regarding the request for Lunesta 2mg #30, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to Lunesta treatment. Finally, there is no indication that Lunesta is being used for short-term use as recommended by guidelines. In the absence of such documentation, the currently requested Lunesta 2mg #30 is not medically necessary.

Lexapro 20mg #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental

Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Stress Related Conditions 395-396, 402

Decision rationale: Regarding the request for Lexapro 20mg #30, Chronic Pain Medical Treatment Guidelines state that selective serotonin reuptake inhibitors may have a role in treating secondary depression. Additionally, guidelines recommend follow-up evaluation with mental status examinations to identify whether depression is still present. Guidelines indicate that a lack of response to antidepressant medications may indicate other underlying issues. Within the documentation available for review, there is no evidence of any recent mental status examinations to determine a diagnosis of depression. Additionally, there is no documentation indicating whether or not the patient has responded to the current Lexapro treatment. In the absence of clarity regarding those issues, the currently requested Lexapro 20mg #30 is not medically necessary.

Soma 350mg #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66 of 127.

Decision rationale: Regarding the request for Soma (Carisoprodol) 350mg #100, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that Soma specifically is not recommended for more than 2 to 3 weeks. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the Carisoprodol. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Soma (Carisoprodol) 350mg #100 is not medically necessary.

Esgic #50: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-Containing Analgesic Agents (BCAs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23 of 127.

Decision rationale: Regarding the request for Esgic, Chronic Pain Medical Treatment Guidelines state that barbiturate containing analgesic agents is not recommended for chronic pain. They go on to state that the potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. As such, the currently requested Esgic is not medically necessary.

Voltaren cream 1% 3 boxes/10 tubes: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112 of 127.

Decision rationale: Regarding the request for Voltaren cream 1% 3 boxes/10 tubes, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there is no indication that the patient has obtained any specific analgesic effect (in terms of percent reduction in pain, or reduced NRS) or specific objective functional improvement from the use of Voltaren gel. Additionally, there is no documentation that the Voltaren gel is for short-term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested Voltaren cream 1% 3 boxes/10 tubes is not medically necessary.