

Case Number:	CM14-0084983		
Date Assigned:	08/08/2014	Date of Injury:	12/31/2001
Decision Date:	10/07/2014	UR Denial Date:	05/28/2014
Priority:	Standard	Application Received:	06/06/2014

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 & Rehabilitation and 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 55-year-old female who reported an injury on 12/31/2001 due to an unknown mechanism. Diagnosis was status post artificial disc replacement at C3-4 and C5-6 with cervical fusion at C4-5, C6-7, and C7-T1 with plates and screws. Past treatments were home exercise program, physical therapy, facet block ablation, and acupuncture. Diagnostic studies were thoracic MRI. Surgical history was surgery on the cervical spine. The physical examination on 06/25/2014 revealed complaints of worsening neck pain and upper back pain that radiated over the bilateral lower extremities. The injured worker has had physical therapy for 2 months and reported improvement of low back pain but worsening of neck and upper back pain. The examination of the cervical spine revealed, upon palpation, it elicited spasms of the paracervical muscles bilaterally. Cervical flexion was to 40 degrees, extension was to 10 degrees, right rotation was to 40 degrees, and left rotation was to 40 degrees. Medications were not reported. The treatment plan was for future surgery of the C3-4 and C5-6 with interbody fusion and plate at the C3-4 and C5-6 levels. The rationale was not submitted. The Request for Authorization was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patches: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm patches. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Lidoderm

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

Decision rationale: The decision for Lidoderm patches is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED such as Gabapentin or Lyrica). This is not a first line treatment and is only FDA approved for postherpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. No other commercially approved topical formulations of Lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

MS Contin 30mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Page(s): 78.

Decision rationale: The decision for MS Contin 30 mg quantity 90 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend documentation of the 4 A's, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behavior. The efficacy of this medication was not provided. Also, the request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

Robaxin 750mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Robaxin Page(s): 64.

Decision rationale: The decision for Robaxin 750 mg is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that Robaxin is an antispasmodic used in low back pain to decrease muscle spasms, although it is sometimes used whether a spasm is present or not. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Norco 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Norco; Ongoing Management Page(s): 75; 78.

Decision rationale: The decision for Norco 10/325 mg quantity 120 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend short acting opioids such as Norco for controlling chronic pain. For ongoing management, there should be documentation of the 4 A's, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behavior. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

Klonopin 0.5mg #60: Upheld

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

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

Decision rationale: The decision for Klonopin 0.5 mg quantity 60 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines do not recommend the use of benzodiazepines as treatment for patients with chronic pain for longer than 3 weeks due to a high risk of psychological and physiological dependency. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. Therefore, continued use would not be supported. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Relpax 40mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Food and Drug Administration: Relpax

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head, Migraine Pharmaceutical Treatment

Decision rationale: The decision for Relpax 40 mg is not medically necessary. Per the Official Disability Guidelines for migraine pharmaceutical treatment, it recommends triptans for migraine sufferers. At marketed doses, all oral triptans (e.g., sumatriptan, brand name Imitrex) are effective and well tolerated. Differences among them are, in general, relatively small, but

clinically relevant for individual patients. A poor response to 1 triptan does not predict a poor response to other agents in that class. Melatonin is recommended as an option given its favorable adverse effect profile. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, it is not medically necessary.

Topamax 100mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 16, 21.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Page(s): 16,17.

Decision rationale: The decision for Topamax 100mg is not medically necessary. The California MTUS guidelines recommend antiepilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30 % - 50% and objective functional improvement. The efficacy for this medication was not reported. The request did not indicate a frequency for the medication. Therefore, the request is not medically necessary.

Effexor 150mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain for general guidelines Page(s): 1.

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

Decision rationale: The decision for Effexor 150 mg is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend antidepressants as a first line medication for treatment of neuropathic pain, and they are recommended especially if pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective functional improvement to include an assessment in the changes in the use of other analgesic medications, sleep quality and duration, and psychological assessments. The efficacy of this medication was not reported. Also, the request does not indicate the frequency for the medication. Therefore, it is not medically necessary.

Aqua therapy x16: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The decision for aqua therapy x16 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend aquatic therapy as an optional form of exercise therapy that is specifically recommended where reduced weight-bearing is desirable. The guidelines indicate the treatment of myalgia and myositis is 9 visits to 10 visits and for neuralgia, neuritis, and radiculitis, it is 8 visits to 10 visits. The rationale for why the injured worker needs to have aquatic therapy was not reported. Also, the request exceeds the recommended guidelines of 9 visits to 10 visits for myalgia and myositis, and for neuralgia, neuritis, and radiculitis, it is 8 visits to 10 visits. The functional outcomes from previous physical therapies were not reported. Therefore, this request is not medically necessary.