MAXIMUS Federal Services

Case Number:	CM14-0209496		
Date Assigned:	12/22/2014	Date of Injury:	01/12/1999
Decision Date:	02/13/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	12/15/2014

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 Family Practice and is licensed to practice in New Jersey. 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 51 year-old male who injured his lumbar spine and right knee on 1/12/99. He had lower back and leg neuropathic pain. He had pain of 6/10. On exam, he had decreased discrimination to light touch along the right posterior lateral lower leg into the dorsum of the foot, and numbness of bilateral upper hamstrings and right anterior thigh. A lumbar MRI showed disc bulge at L3-4 and L5-S1 with mild right neural foraminal narrowing. He was diagnosed with lumbar spine strain, left lower extremity complex regional pain syndrome, and right knee strain status post arthroscopy. He had radiofrequency ablation of the bilateral L4-5 and L5-S1 facet joints in 3/2014 with reducation of pain. He weaned off Butrans patch in 11/2014. His medications decreased his pain by 50% and lasted 3-4 hours in duration. His 3/2014 urine drug screen showed appropriate results. He is a graduate of a functional restoration program. The current request is for Lunesta, Cymbalta, Nroco, Provigil, Senokot, Voltaren gel, and outpatient for chronic lumbar pain and complex regional pain syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Lunesta 3mg #60, refills 2: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request is considered not medically necessary. The request is for retrospective prescription of Lunesta. MTUS does not have guidelines for Lunesta, therefore, ODG was used. According to ODG, Lunesta is only recommended for short-term use. "They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. In general, receiving hypnotic prescriptions was associated with greater than a threefold increased hazard of death even when prescribed less than 18 pills/year. Previously recommended doses can cause impairment to driving skills, memory, and coordination as long as 11 hours after the drug is taken. Despite these long-lasting effects, patients were often unaware they were impaired." The request for a 1 month supply with 2 refills exceeds the recommended three week limit. The patient is also using 6mg per day which exceeds the maximum daily dosage of 3mg. There also has not been any documentation of attempted improvement in sleep hygiene. Because of these reasons, the request is considered not medically necessary.

Cymbalta 60mg #60, refills 2: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duloxetine (Cymbalta) Page(s): 43-44.

Decision rationale: The request is considered not medically necessary. The patient has lumbar pain radiating to lower extremities and neuropathic pain. Cymbalta is recommended for neuropathic pain and radiculopathy which the patient has. However, the maximum dose recommended for neuropathic pain is 60mg which the patient has exceeded. His dose is recommended only for the diagnosis of fibromyalgia which he does not have. Therefore, the request is considered not medically necessary as stated.

Norco 10/325mg #120: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-79.

Decision rationale: The request for Norco is medically necessary. The patient has been on opiates for unclear amount of time with objective documentation of the improvement in pain and increase in functional capacity. With medications, his pain decreased 50% and lasted for 3-4 hours. He does have constipation which is controlled by Senokot. There is documentation of the four A's of ongoing monitoring: pain relief, side effects, physical and psychosocial functioning, and aberrant drug-related behaviors. There was a urine drug screen that was appropriate with

regular UDS done every 6 months and documentation of no aberrant behavior. Because of these reasons, the request for Norco is considered medically necessary.

Provigil 100mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request is considered not medically necessary. ODG guidelines were referenced as MTUS does not address the use of modafinil. Provigil is used to treat excessive sleepiness associated with narcolepsy, obstructive sleep apnea, and shift work sleep disorder which the patient has not been diagnosed with. It is not used to treat sleepiness associated with narcotic use. Therefore, the request is considered not medically necessary.

Senokot #90: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request is considered medically necessary. ODG guidelines were used as MTUS does not address Senokot use. Senokot is a stool softener. The patient has been on chronic opioid use which led to opioid-induced constipation which has been controlled well by senokot. The patient will continue on chronic opioids at this point and will require continued use of senokot as needed. Therefore, the request is considered medically necessary at this time.

Voltaren Gel AAA #1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request is not medically necessary. The use of topical analgesics is largely experimental in use with few randomized controlled trials to determine efficacy or safety. The efficacy of topical NSAIDs have shown inconsistent results in studies. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis and tendinitis, but either not afterward, or with a diminishing effect over another 2-week period. These medications may be useful for chronic musculoskeletal pain, but

there are no long-term studies of their effectiveness or safety. The patient has had chronic, back, and knee pain and was using Voltaren longer than two weeks. It is recommended only for short-term use. It is not recommended for neuropathic pain. Therefore, the request is considered not medically necessary.

Outpatient, for chronic lumbar pain and complex regional pain syndrome of the left lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-289.

Decision rationale: The request is considered not medically necessary as it is unclear what is being requested: outpatient therapy or outpatient visits? The utilization review has this listed but does not address the request.