

Case Number:	CM15-0010752		
Date Assigned:	01/28/2015	Date of Injury:	06/10/2010
Decision Date:	03/25/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	01/20/2015

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 58 year old female, who sustained a work/ industrial injury while assisting a patient on 3/12/15. She has reported symptoms of mid back pain, lower backache, and right knee pain. Pain was rated 2/10 with medications and 9/10 without. Prior medical history includes diabetes mellitus, hypertension, asthma, and arthritis. Surgeries included a right knee surgery. The diagnoses have included knee pain, pain in joint lower leg with psychological factors and an orthopedic condition. Per the treating physician's report dated 10/23/14, there was report of right sided antalgic gait with use of a cane, the paravertebral muscles had tenderness and tight muscle bands on both sides, the right knee had restricted range of motion with flexion limited to 90 degrees and extension limited to 0 degrees, had crepitus, with tenderness to palpation over the lateral joint line, medial joint line and pes anserine. The right knee was stable to valgus stress in extension and at 30 degrees, with mild effusion in the right knee joint. McMurray's test was negative. The left knee was negative. Treatment to date has included oral analgesics, physical therapy, sleep study, aquatic therapy, cognitive testing, and Transcutaneous Electrical Nerve Stimulation (TENS) unit. Medications included Atenolol, Cymbalta, Hydrocodone/Acetaminophen, and Lunesta. The treating physician requested Cymbalta, Lidoderm Patch, Rozerem, Vicodin, Voltaren 1% gel, and Zanaflex. On 1/8/15, Utilization Review non-certified a Lidoderm 5% Patch (700 mg/patch) #30; Zanaflex 4 mg #30, and Vicodin 5-300 mg #30, and approved Cymbalta 60 mg #30, Rozerem 8 mg #30 and Voltaren 1% Gel #30, noting the Medical treatment Utilization Schedule (MTUS) Guidelines: Topical Analgesics, Antidepressants for chronic pain, Muscle relaxants, Opioids.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm 5% patch 0/0 (700mg patch) #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS, Topical analgesics Page(s): 56-57, 111-112.

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 antidepressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is 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 patch is not recommended.

Zanaflex 4mg tablet #30: 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 CA MTUS (2009), Muscle relaxants Page(s): 63, 66.

Decision rationale: Zanaflex (Tizanidine) 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 (2009), muscle relaxants have not been considered any more effective than non-steroidal antiinflammatory drugs (NSAIDs) for pain or overall improvement. There is also no additional benefit shown in combination with NSAIDs. In addition, sedation is the most commonly reported adverse effect of muscle relaxant medications. In this case, the patient had no reported lumbar spasm on physical exam. Medical necessity for the requested medication has not been established. Zanaflex is not medically necessary.

Vicodin 5-300mg tablet #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS (2009), Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Opioids

Decision rationale: According to ODG, chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added. According to ODG and MTUS, Vicodin is a short-acting opioid analgesic, and is in a class of drugs that has a primary indication to relieve symptoms related to pain. Opioid drugs are available in various dosage forms and strengths. They are considered the most powerful class of analgesics that may be used to manage both acute and chronic pain. These medications are generally classified according to potency and duration of dosage duration. 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 status, or response to ongoing opioid analgesic therapy. In addition, guidelines necessitate documentation that the prescriptions are from a single practitioner and taken as directed. This was not documented in the records. Medical necessity of the requested item has not been established. The certification of the requested Vicodin is not recommended.

Rozerem 8mg #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 Sedative Hypnotics Medscape Internal Medicine

Decision rationale: Rozerem is in a class of sleep agents that selectively binds to MT1 and MT 2 receptors in the supra-chiasmatic nucleus instead of binding to GABA receptors such as, drugs like Zolpidem, Eszopicione and Zalepon. Rozerem is approved by the FDA for long-term use. In this case there is no documentation of a diagnosis of insomnia. In addition, there is documentation that this medication previously caused daytime drowsiness and was been previously denied. Medical necessity for the requested medication has not been established. The requested item is not medically necessary.