

Case Number:	CM13-0017704		
Date Assigned:	10/11/2013	Date of Injury:	06/05/2002
Decision Date:	02/07/2014	UR Denial Date:	08/15/2013
Priority:	Standard	Application Received:	08/28/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice, and is licensed to practice in Texas. 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 physician 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 patient is a 73 year old male who reported an injury on 06/05/2002, the mechanism of injury was not provided. The patient received conservative care and was diagnosed with lumbar strain with residual chronic myofascial pain, and was determined to be permanent and stationary on 12/24/2002. He underwent a bilateral laminectomy, facetectomy, and foraminotomy for the S1, L5, L4, and L3 and a bilateral partial laminectomy of L2 on 04/06/2004. On 07/23/2013 the patient returned to the treating physician and reported a significant increase in pain to the lumbar back and lower extremities, although it is not quantified on a VAS scale. Up until this time the patient's pain was noted to be stable, and managed by medications and aquatic therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription of Lidoderm 5% #60 with 2 refills: Upheld

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

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

Decision rationale: Lidoderm is recommended for neuropathic pain by the MTUS Chronic Pain Guidelines only after there has been evidence of failure with first line medications to include

antidepressants and anti-epileptics. The Guidelines do not recommend the use of Lidoderm in treating chronic neuropathic pain. There is no objective documentation of neuropathic findings provided in the medical records. Therefore, the request for Lidoderm 5% patch #60 with 2 refills is not medically necessary and appropriate.

One prescription of Trazodone 50mg #60 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): s 13-16.

Decision rationale: The MTUS Chronic Pain Guidelines recommend antidepressants as a first line treatment for neuropathic pain but state that they have a short term limited benefit for non-neuropathic pain. Guidelines also recommend that efficacy be determined by objective improvements in pain level and functioning. According to the records provided for review, there was no evidence of the patient having neuropathic complaints, nor was there any substantiating documentation of decreased pain levels and increased function. Therefore, the request for Trazodone 50mg #60 with 2 refills is not medically necessary and appropriate.

One prescription of Voltaren 1% gel #5 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: The MTUS Chronic Pain Guidelines recommend the use of Voltaren 1% gel for patients with osteoarthritis of the ankle, elbow, foot, hand, knee, and wrist. The documentation submitted for review did not indicate the patient had osteoarthritis of the ankle, elbow, foot, hand, knee, and wrist. The patient was noted to have low back, buttock and lower extremity pain. The MTUS Chronic Pain Guidelines do not recommend the use of the requested medication for the spine or hips or for long-term use. Due to the lack of documentation it is unclear if the patient had any period of use of the medication. Given the information submitted for review the request for 1 prescription of Voltaren 1% gel #5 with 3 refills is not medically necessary and appropriate.