

Case Number:	CM13-0018534		
Date Assigned:	10/11/2013	Date of Injury:	07/04/2010
Decision Date:	08/13/2014	UR Denial Date:	07/30/2013
Priority:	Standard	Application Received:	08/29/2013

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Massachusetts. 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:

According to the documents for review, the patient is a 40 year old male with a date of injury of 7/4/2010. The patient sustained a low back injury with lower extremity pain complaints and radiculopathy. The patient was diagnosed to the left L5 nerve root impingement and a ruptured L4/L5 disc, and is status post microdiscectomy at L4/L5. Physical exam is notable for limitation of lumbar spine motion and pain with decreased spine flexion noted at 20 degrees and with spine extension at five degrees. He ambulates with the assistance of the cane. MRI lumbar spine dated 3/8/13, demonstrates scar tissue in the left lateral recess surrounding the traversing left L5 nerve root. The patient is currently taking Norco 10/325mg 1 tab TID, Lidoderm patch and OxyContin 30 mg TID. Request from Lidoderm patch and OxyContin was requesting and denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

LIDODERM PATCH #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
<Lidoderm> page(s) 56 Page(s): 56.

Decision rationale: According to the California MTUS, 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 anti-depressants or an AED such as Gabapentin). 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 anti-depressants 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. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. Therefore medical necessity for the requested item has not been established.

OXYCONTIN 30MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids page(s) 74-96 Page(s): 74-96.

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines section on opioids p 74-97, On-Going Management, (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. The MTUS guidelines

recommend that dosing not exceed 120 mg oral morphine equivalents per day, and for patient taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose. In general, the total daily dose of opioid should not exceed 120 mg oral morphine equivalents. Rarely, and only after pain management consultation, should the total daily dose of opioid be increased above 120 mg oral morphine equivalents. There is no current documentation of baseline pain, pain score with use of opioids, functional improvement on current regimen, side effects. Additionally, according to the documents available for review, there is no evidence of a pain consultation despite the fact that the patient is been maintained on opiates for greater than three months and is on a total daily of greater than 120 mg of oral morphine equivalents. Therefore medical necessity for the requested item has not been established.