

Case Number:	CM13-0034150		
Date Assigned:	03/19/2014	Date of Injury:	03/05/2011
Decision Date:	04/23/2014	UR Denial Date:	09/20/2013
Priority:	Standard	Application Received:	10/11/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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:

This patient is a 55-year-old female with a date of injury of 03/05/2011. The listed diagnoses are: S/P fluoroscopically-guided permanent percutaneous spinal cord stimulator implant. Complex regional pain syndrome of right foot, right ankle, and right leg. S/P fifth metatarsal surgery of the right foot dated 2012. Right foot internal derangement. Right foot fracture. According to report dated 09/16/2013, the patient presents with continued right leg, right ankle, and right foot pain. The patient reports increased left leg pain and would like stronger medication for her increased pain. The patient's current medication includes losartan 1 tab, triamterene, clonidine, Colace, oxycodone 7.5/325 mg, Lexapro, and Gralise 600 mg. Examination revealed there is right foot allodynia, hyperesthesia, hyperalgesia, and trophic skin changes. There is 1+ swelling of the foot. Tenderness upon palpation of the entire foot is noted. The patient was given her industrial related medications. Risks and benefits surrounding longterm opiate use for the treatment of chronic pain was discussed with patient.

IMR ISSUES, DECISIONS AND RATIONALES

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

LIDODERM PATCH #30 WITH 4 REFILLS: Upheld

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

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

Decision rationale: This patient presents with right leg, right ankle, and right foot pain. The treater is requesting Lidoderm patches #30 with 4 refills. The MTUS Guidelines page 112 state under lidocaine indications are for neuropathic pain, "Recommended for localized peripheral pain after there has been evidence of trial of first line therapy (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica)." MTUS further states that topical lidocaine in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain and that Lidoderm is also used off label for diabetic neuropathy. MTUS supports the use of Lidocaine patches for neuropathic pain only after trial of tricyclic antidepressants, or AEDs and is indicated for "localized peripheral pain." Review of medical records stating from 03/04/2013 to 09/16/2013 show that while the patient may not suffer from neuropathic pain, the patient does have "localized peripheral pain," namely, foot and ankle pain. Recommendation is for authorization.

OXYCODONE 7.5/325MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Page(s): s 60-61.

Decision rationale: This patient presents with continued right leg, right ankle, and right foot pain. The treater is requesting oxycodone 7.5/325 mg #120. For chronic opiate use MTUS Guidelines page 88, 89 require functioning documentation using a numerical scale or validated instrument at least once every six months. Documentation of the 4 A's analgesia, ADLs, adverse side effects, adverse behavior are required. Furthermore, under outcome measures, it also recommends documentation of current pain, average pain, least pain, time it takes for medication to work, duration of pain relief with medication, etc. In the reports provided for review dating from 03/04/2013 to 09/16/2013, there are no discussions regarding how any of the medications prescribed have been helpful in terms of decreased pain or functional improvement as required by MTUS. The patient was prescribed oxycodone on 06/26/2013. Subsequent reports provide no discussions regarding the efficacy of this medication. In addition, the treater provides no numerical scales to assess the patient's pain or function. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the patient should be weaned off of Oxycodone as outlined in MTUS Guidelines, and recommendation is for denial.

GRALISE 600MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 18-19.

Decision rationale: This patient presents with continued complaints of right leg, right ankle, and right foot pain. The treater is requesting Gralise 600 mg #30 with 1 refill. The MTUS Guidelines page 18 and 19 has the following regarding the gabapentin: "Gabapentin has shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain." In this case, this patient does not present with any neuropathic pain. In addition, medical records indicate this patient has been taking gabapentin since 03/04/2013 with no indication of its efficacy. In none of the 7 progress reports the treater discusses the efficacy of gabapentin. MTUS page 60 requires documentations of pain assessment and functional improvement when medications are used for chronic pain. The requested Gralise is not medically necessary and recommendation is for denial.

LEXAPRO 20MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): s 13-15.

Decision rationale: This patient presents with continued complaints of right leg, right ankle, and right foot pain. The treater is requesting Lexapro 20 mg #30. Report dated 06/20/2013 indicates the patient will be prescribed Lexapro. Subsequent reports dated 07/10/2013, 07/24/2013, and 09/16/2013 provide no discussions as to why this medication is prescribed and if this medication is providing any kind of benefit to this patient. The MTUS Guidelines on antidepressants page 13 and 15 states "Recommended as the first line option for neuropathic pain and as a possibility for non-neuropathic pain, tricyclic are generally considered a first line agent unless they are ineffective, poorly tolerated or contradictive. Assessment of treatment efficacy should include not only pain outcomes but also an evaluation of function, changes and use of other analgesic medication, sleep quality and duration and psychological assessment." Although MTUS allows for antidepressants for neuropathic and non-neuropathic pain, the treater does not discuss the efficacy of this medication which should include pain outcomes, functional evaluation, etc. The requested Lexapro 20 mg #30 is not medically necessary and recommendation is for denial.