

Case Number:	CM13-0040569		
Date Assigned:	12/20/2013	Date of Injury:	04/28/1998
Decision Date:	02/18/2014	UR Denial Date:	10/08/2013
Priority:	Standard	Application Received:	10/29/2013

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 Internal Medicine, has a subspecialty in Cardiology 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 60-year-old female who reported a work related injury on 04/28/1998. Per clinical documentation, the patient has complaints of chronic and severe neck and back pain due to cervical and lumbar disc disease, stenosis, and degenerative myofascial pain syndrome of her cervical spine. Cervical exam of the patient revealed tenderness to palpation to paraspinals with radiculopathy into upper extremities bilaterally. The patient was noted to have spasms bilaterally in cervical and lumbar and decreased strength in left and right upper extremities. A request has been made for Lidoderm 5% patch #30 with 5 refills, ketamine/diclofenac/endo/lido 240 grams, baclofen/cyclo/flu/ketamine/lido 240 gram with 2 refills, and trigger point injection to the left suprascapular region.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm 5% patch, #30 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: The Physician Reviewer's decision rationale: The patient's medications include hydrocodone, Voltaren gel, Omeprazole, Restoril, Arthrotec, and Lidoderm patch.

California Chronic Pain Medical Treatment Guidelines indicate that Lidoderm is the brand name for a lidocaine patch, and that topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy, to include tricyclic or SNRI antidepressants or an AED such as Gabapentin or Lyrica. There was no clinical documentation stating the patient had tried and failed first line therapy. Furthermore, guidelines state that Lidoderm patch is only FDA approved for postherpetic neuralgia and further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. Therefore, the request for Lidoderm 5% patch, #30 with 5 refills is non-certified.

Ketamine/Diclofenac/Indo/Lido 240gm: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Topical Analgesics Page(s): 111-113.

Decision rationale: The Physician Reviewer's decision rationale: California Chronic Pain Medical Treatment Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Guidelines further state that any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Ketamine is only recommended for treatment of neuropathic pain in cases in which all primary and secondary treatment has been exhausted. Guidelines further state that no commercially approved topical formulations of lidocaine are indicated for neuropathic pain. Formulations that do not involve a dermal patch system are generally indicated as local anesthetics and antipyretics. Guidelines state that topical NSAIDs are recommended for short term use of 4 weeks to 12 weeks, and there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder, and there is no evidence to support the use of topical NSAIDs for neuropathic pain. As such, the decision for Ketamine/Diclofenac/Indo/Lido 240gm is non-certified.

Baclofen/Cyclo/Flu/Ketamine/Lido 240gm with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Topical Analgesics Page(s): 111-113.

Decision rationale: The Physician Reviewer's decision rationale: California Chronic Pain Medical Treatment Guidelines indicate that topical baclofen is not recommended as there is no peer reviewed literature to support the use of topical baclofen. Guidelines further state that topical analgesics are compounded as monotherapy or in combination for pain control and there is little to no research to support the use of many of these agents. Furthermore, the addition of cyclobenzaprine to other agents is not recommended. Guidelines state that any compounded product that contains at least 1 drug (or drug class) that is not recommended is not

recommended. Therefore, the decision for Baclofen/Cyclo/Flu/Ketamine/Lido 240gm with 2 refills is non-certified.

Trigger point injection to the left suprascapular region: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Trigger point injections Page(s): 122.

Decision rationale: The Physician Reviewer's decision rationale: California Chronic Pain Medical Treatment Guidelines state that trigger point injections are only recommended for myofascial pain syndrome with limited lasting value and are not recommended for radicular pain. Criteria for the use of trigger point injections include documentation of circumscribed trigger points with evidence upon palpation of a twitch response, as well as referred pain. There was no evidence given, per patient's physical exam, of documentation of the patient's trigger points. Furthermore, the patient was noted to have radiculopathy into upper extremities bilaterally, which does not meet guideline criteria for the use of trigger point injections. Therefore, the decision for trigger point injection to the left suprascapular region is non-certified.