

Case Number:	CM13-0049637		
Date Assigned:	12/27/2013	Date of Injury:	04/14/1998
Decision Date:	11/14/2014	UR Denial Date:	10/30/2013
Priority:	Standard	Application Received:	11/08/2013

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 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:

The underlying date of injury in this case is 04/14/1998. The date of the utilization review under appeal is 10/30/2013. On 09/09/2013, the patient was seen in primary treating physician follow-up regarding ongoing neck pain and back pain. The patient reported radiation of pain with numbness and weakness down both legs, worse on the left than the right. The patient reported that she was taking Soma, Norco, and OxyContin and that these provided pain relief and increased function. The patient reported that a stimulator implanted in the past was not providing much pain relief and she was relying on medication. On exam the patient had tenderness throughout the entire spine as well as decreased sensation in the left upper and lower extremities and diffuse weakness in the left upper and left lower extremity. The treatment plan was to request CT imaging of the entire spine as well as a gastrointestinal consultation regarding persistent GI upset and continuation of medications. The treating physician also discussed with the patient the possibility of reducing her pain medications to see if her diffuse symptoms would decrease with a reduction in opioid medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

#60 LIDOCAINE PATCHES 5 PERCENT: 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 Topical Analgesics Page(s): 112.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on topical analgesics, page 112, recommends lidocaine only for localized peripheral neuropathic pain. The records do not document such a diagnosis at this time, and the rationale for this request therefore is not apparent. Additionally, it is unclear why lidocaine would be indicated simultaneously both as patch and cream as has been recommended. For these reasons, this request is not supported by the guidelines. Overall, this request is not medically necessary.

#5 G LIDOCAINE CREAM 5 PERCENT: 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 Topical Analgesics Page(s): 112.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on topical analgesics, page 112, recommends lidocaine only for localized peripheral neuropathic pain. The records do not document such a diagnosis at this time, and the rationale for this request therefore is not apparent. Additionally, it is unclear why lidocaine would be indicated simultaneously both as patch and cream as has been recommended. For these reasons, this request is not supported by the guidelines. Overall, this request is not medically necessary.

SOMA 350MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CARISOPRODOL, NECK AND UPPER BACK COMPLAINTS, FOREARM, WRIST, AND.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Soma Page(s): 29.

Decision rationale: The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on Soma, page 29, state that this medication is not indicated for long-term use and that abuse has been noted to augment the effects of other drugs. The records at this time do not provide an alternate rationale to support an indication for this medication on a chronic basis. This request is not medically necessary.

AMBIEN CR 12.5MG P O: 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 Official Disability Guidelines (ODG), Pain, Ambien

Decision rationale: This medication is not discussed in the Medical Treatment Utilization Schedule. The Official Disability Guidelines/Treatment in Workers Compensation/Pain, discuss Ambien and recommend its use at most up to 10 days for short-term treatment of insomnia. The current use of this medication in a more chronic setting is not supported by the treatment guidelines, and the records do not provide an alternate rationale for ongoing or chronic use of Ambien. Overall, this request is not medically necessary.