

Case Number:	CM13-0058068		
Date Assigned:	12/30/2013	Date of Injury:	05/06/2007
Decision Date:	03/20/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	11/26/2013

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 Physical Medicine & 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 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 38 year-old male with a date of injury of 05/06/2007. The listed diagnoses per [REDACTED] dated 09/18/2013 are: 1) Joint pain-shoulder 2) Psychogenic pain 3) Depressive disorder 4) Anxiety 5) Lumbar disc displacement 6) Lumbosacral disc degenerative disease According to report dated 09/18/2013 by [REDACTED], the patient presents with chronic low back pain, left shoulder internal derangement and chronic pain syndrome. Patient reports continuing dysfunction that is worsening in his left upper extremity and hand. On examination, patient's grip strength was markedly diminished. There was tenderness to flexion and extension through the forearm and wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

. Lidocaine patch 5%, #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): 112.

Decision rationale: The Physician Reviewer's decision rationale: The patient presents with chronic low back pain, left shoulder internal derangement and chronic pain syndrome. Treater is requesting Lidocaine patches. The MTUS guidelines page 112 state under Lidocaine states indications are for neuropathic pain. "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). Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy." Lidocaine patches are indicated for neuropathic pain only after trial of tri-cyclic, anti-depressants, or AEDs. It is also indicated for "localized peripheral pain." Review of medical records from 02/12/2013 to 09/18/2013 does not show that this patient suffers from neuropathic pain or localized peripheral pain. The patient has low back and shoulder pains which are not indicated for lidoderm patches. The requested lidocaine patches are not medically necessary and recommendation is for denial.

AndroGel pump gel 20.25 mg/ACT (1.62%), #225: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The Physician Reviewer's decision rationale: The patient presents with chronic low back pain, left shoulder internal derangement and chronic pain syndrome. Treater requests Andro gel pump for "hypogonadism related to the chronic use of opioids." The MTUS, ACOEM and ODG guidelines do not discuss AndroGel pumps. Therefore an alternative resource was consulted. The FDA has the following regarding AndroGel. "ANDROGEL 1.62% is a prescription medicine that contains testosterone. 1.62% is used to treat adult males who have low or no testosterone. It is recommended that healthcare provider's test patient's blood before they start and while they are taking ANDROGEL 1.62%." ODG guidelines also states, "recommended in limited circumstances for patients taking high-dose long-term opioids with documented low testosterone levels." In this case, the treater does not provide the patient's testosterone levels, no evidence of gynecomastia on exam, and there are no reports of blood tests prior to initiating this medication. Given the lack of discussion of patient's hypogonadism or testosterone levels the Andro gel pump is not recommended.

Cialis Tabs 20mg, #20: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation AETNA guidelines.

Decision rationale: The Physician Reviewer's decision rationale: The patient presents with chronic low back pain, left shoulder internal derangement and chronic pain syndrome. Treater

requests Cialis as needed for erectile dysfunction due to pain. The treater does not go into any details regarding patient erectile dysfunction other than he has it due to opioid use. MTUS, ACOEM and ODG guidelines do not discuss Cialis specifically. AETNA guidelines, however, require comprehensive physical/examination and lab work-up for diagnosis of ED including medical, sexual and psychosocial evaluation. While Cialis is appropriate for ED, ED must be appropriately diagnosed. Recommendation is for denial.