

Case Number:	CM13-0062455		
Date Assigned:	12/30/2013	Date of Injury:	04/14/1998
Decision Date:	04/11/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/06/2013

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 Pain Medicine, 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 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 patient is a 46-year-old female who reported an injury on 04/14/1998. The mechanism of injury was not stated. The patient is diagnosed with late stage complex regional pain syndrome, status post spinal cord stimulator implantation, and generator site pain. The patient was seen by [REDACTED] on 11/07/2013. The patient reported persistent pain in the left upper and lower extremity. Physical examination revealed an antalgic gait, tenderness to palpation, and marked weakness, contracture and atrophy in the left upper and lower extremity. Treatment recommendations included continuation of current medication including Soma, Ambien, Norco, lidocaine, Zofran, OxyContin, Prilosec, and ibuprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

LIDOCAINE TOPICAL CREAM 5% #5G: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

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

Decision rationale: The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety.

Lidocaine is indicated for neuropathic pain and localized peripheral pain after there has been evidence of a trial of first line therapy. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. There is no documentation of a failure to respond to first line oral medication with antidepressants and anticonvulsants. Additionally, the MTUS Chronic Pain Guidelines do not recommend lidocaine in the formulation of a cream. Based on the clinical information received and the MTUS Guidelines, the request for Lidocaine topical cream 5% #5g is not medically necessary and appropriate.

PREVACID 30MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68/69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68-69.

Decision rationale: The MTUS Chronic Pain Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a non-selective NSAID. As per the documentation submitted, there is no evidence of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. As such, the request for Prevacid 30mg #30, by mouth daily, three (3) times a day, as needed is not medically necessary and appropriate.

IBUPROFEN 800MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51, 67, 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

Decision rationale: The MTUS Chronic Pain Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain. There is no evidence of a satisfactory response to treatment. Therefore, the request for Ibuprofen 800mg #90, by mouth, three (3) times a day, as needed is not medically necessary and appropriate.

ZOFRAN 8MG #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation the Official Disability Guidelines, Pain Chapter, Online Version

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Chronic Pain Chapter, section on Ondansetron and Antiemetic

Decision rationale: The Official Disability Guidelines state Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. It has been FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment, and has been also approved for postoperative use. The patient does not meet criteria for the requested medication. As such, the request for Zofran 8mg #90, one (1) tab by mouth, as needed is not medically necessary and appropriate.