

Case Number:	CM14-0001430		
Date Assigned:	01/22/2014	Date of Injury:	01/26/2006
Decision Date:	06/23/2014	UR Denial Date:	12/10/2013
Priority:	Standard	Application Received:	01/03/2014

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 Pain Medicine and is licensed to practice in Texas and Ohio. 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 injured worker is a 35-year-old female who reported an injury on 01/28/2008. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to her low back. This ultimately resulted in a transforaminal lumbar interbody fusion at the L4-5 and L5-S1. The injured worker's postsurgical back pain was managed with medications. The injured worker was evaluated on 11/15/2013. It was documented the injured worker had a mildly antalgic gait with restricted range of motion secondary to pain and 3.5/5 motor strength of the right extensor hallucis longus and hip flexors with diminished sensation over the entire right lower extremity. The injured worker's diagnoses included chronic musculoligamentous sprain/strain, industrially related depression, industrially related bladder dysfunction, gastrointestinal (GI) distress. The injured worker's treatment plan included the continuation of medications to include Ativan at bedtime and Lyrica.

IMR ISSUES, DECISIONS AND RATIONALES

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

ATIVAN 1 MG QUANTITY 15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BENZODIAZEPINES Page(s): 24. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
BENZODIAZEPINES Page(s): 24.

Decision rationale: The Chronic Pain Guidelines do not recommend the long term use of benzodiazepines due to a high risk of physiological and psychological dependence. The clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended period of time. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Ativan 1 mg is not medically necessary or appropriate.

LYRICA 75 MG QUANTITY 150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Antiepilepsy drugs (AEDs) Page(s): 19-20.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Antiepilepsy drugs (AEDs); Medications for chronic pain Page(s): 16, 60.

Decision rationale: The Chronic Pain Guidelines support the use of anticonvulsants as a first line medication in the management of chronic pain; however, the clinical documentation submitted for review does indicate that the injured worker has been on this medication for an extended duration of time. The guidelines recommend that medications used in the management of chronic pain be supported by documented functional benefit and effective pain relief. The clinical documentation submitted for review does not provide any evidence that the injured worker has pain relief or functional benefit related to medication usage. Therefore, continued use would not be supported. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Lyrica 75 mg # 150 is not medically necessary or appropriate.

LIDODERM 5% PATCH: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Topical Analgesics Page(s): 112. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

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

Decision rationale: The Chronic Pain Guidelines recommend this medication as a treatment option for injured workers who have failed to respond to anticonvulsants in oral formulations. The clinical documentation submitted for review does not provide any evidence that the injured worker has failed to respond to a trial of anticonvulsants. Additionally, the request as it is submitted does not clearly define a frequency or duration of treatment. In the absence of this

information, the appropriateness of the request itself cannot be determined. As such, the requested Lidoderm 5% patch is not medically necessary or appropriate.