

Case Number:	CM14-0102504		
Date Assigned:	07/30/2014	Date of Injury:	06/01/2002
Decision Date:	10/14/2014	UR Denial Date:	06/12/2014
Priority:	Standard	Application Received:	07/02/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma. 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 53-year-old female who reported an injury on 08/01/2002 due to an unknown mechanism. Diagnoses were impingement syndrome, cubital tunnel bilateral, carpal tunnel syndrome bilateral postoperative on left, epicondylitis lateral, left, postoperative on the left, supinator tunnel, left. Diagnostic studies were MRI of the right shoulder and nerve conduction velocity testing. The impression of the MRI revealed no acute findings, status post acromioplasty. Surgical history was left shoulder arthroscopic acromioplasty with partial distal claviclectomy, left elbow extensor slide and supinator tunnel release, left carpal tunnel release, right ulnar nerve release with medial epicondylectomy, and carpal tunnel release, right shoulder arthroscopic acromioplasty, and left shoulder arthroscopic distal claviclectomy. Physical examination was not reported. Medications were Lidoderm patch 5%, amlodipine, hydrochlorothiazide, and cetirizine. Treatment plan was to start Butrans transdermal system, Lyrica, and Terocin patch. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lyrica capsule 50 mg orally twice a day #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica Page(s): Pages 14 and 15.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drugs Page(s): 16,17.

Decision rationale: The decision for Lyrica capsule 50 mg orally twice a day #60 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend antiepilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30% to 50% and objective functional improvement. The efficacy of this medication was not reported. The injured worker was started on Lyrica on 06/25/2014. No other reports were submitted to justify its continued use. Therefore, the request is not medically necessary.

Lidoderm patch 5% 10 X 14 cm patch 12 hours day/30 days, 30 patches, Refills 5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine indication Page(s): Pages 117 and 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, Topical Salicylates, Topical Analgesics, Lidoderm, Page(s): 105,111,112.

Decision rationale: The decision for Lidoderm patch 5% 10 X 14 cm patch 12 hours day/30 days, 30 patches, Refills 5 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that topical salicylates are recommended and topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Lidocaine is only recommended in a Lidoderm patch. The efficacy of this medication was not reported. The medical guidelines do not support the use of topical analgesics unless antidepressants and anticonvulsants have failed. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, the request is not medically necessary.

Butrans Transdermal System film, extended release, 6 mcg/hr, 1 patch transdermally, once a week, 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): Pages 82-88.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Page(s): 78.

Decision rationale: The decision for for Butrans Transdermal System film, extended release, 6 mcg/hr, 1 patch transdermally, once a week, 4 weeks is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend for ongoing management of opioids that the 4 A's should be documented as including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The 4 A's of ongoing management were

not reported for this medication. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, the request is not medically necessary.