MAXIMUS Federal Services

Case Number:	CM14-0102934		
Date Assigned:	09/16/2014	Date of Injury:	12/08/2006
Decision Date:	10/15/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/03/2014

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, 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 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 53 year old with an injury date on 12/08/04. Patient complains of persistent lower lumbar pain, mid-back pain, and cervical pain per 9/23/13 report. The utilization review letter dated 6/17/14 cites a 4/28/14 report that also shows complaints of right shoulder and right elbow pain rated 7-8/10. Based on the utilization review letter dated 6/17/14, the diagnosis is sprain/strain of unspecified site of shoulder and upper arm. The utilization review dated 6/17/14 cites a 4/28/14 physical examination that shows right elbow range of motion restricted in all planes. No physical examination of the back was included in provided reports. [redacted] is requesting Voltaren 1% gel, 2 refills and Lidoderm 5% 1 refills. The utilization review determination being challenged is dated 6/17/14 and denies Voltaren due to lack of documentation of efficacy, and denies Lidoderm as further research is required to recommend this treatment for chronic neuropathic pain disorders other than post-heroic neuralgia. [redacted] is the requesting provider, and he provided a single treatment report from 9/23/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% Gel, 2 refills: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Inflammatory Medications , NSAIDs (Non-Steroidal Anti-Inflammatory Drugs)NSAIDs, Specific D.

Decision rationale: This patient presents with back pain, neck pain, right shoulder pain, and right elbow pain and is s/p right shoulder arthroscopy x2 of unspecified date. The provider has asked for Voltaren 1% gel, 2 refills. The utilization review letter dated 6/17/14 states the request for Voltaren was made as patient is unable to tolerate oral medication due to GI upset. According to MTUS, Voltaren gel 1% (Diclofenac) is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, the patient does present with peripheral joint pain. The requested Voltaren 1% gel, 2 refills appears reasonable and within MTUS guidelines. Recommendation is for authorization.

Lidoderm 5%, 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine Patch) Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine Patch), Topical Analgesics Page(s): 56-57, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines, Lidoderm Patches.

Decision rationale: This patient presents with back pain, neck pain, right shoulder pain, and right elbow pain and is s/p right shoulder arthroscopy x2 of unspecified date. The provider has asked for Lidoderm 5% 1 refills. MTUS guidelines page 57 states, "topical Lidocaine may be 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)." MTUS Page 112 also states, "Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain." When reading Official Disability guidelines (ODG), it specifies that Lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. In this case, the patient does present with localized and peripheral joint pain in the shoulder and elbow but these are non-neuropathic pains. Requested Lidoderm patches are only indicated for neuropathic pain conditions that are peripheral and localized. Recommendation is for denial.