

Case Number:	CM14-0013426		
Date Assigned:	02/26/2014	Date of Injury:	11/22/2006
Decision Date:	07/24/2014	UR Denial Date:	01/25/2014
Priority:	Standard	Application Received:	02/03/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 37-year-old male who has submitted a claim for total hip replacement with pain, leg length discrepancy, left knee pain, herniated nucleus pulposus and abnormal gait associated with an industrial injury date of November 22, 2006. Medical records from 2013-2014 were reviewed. The patient complained of low back pain, grade 2/10 in severity. The pain was radiating from the back to the left ankle. There was stabbing sensation on the left hip, and pins and needles sensation inside the left leg and knee. There was also intermittent numbness. There was thigh pain radiating to the left foot and an aching right hip when sitting. Physical examination showed slight limited flexion, sacroiliac extension, lateral flexion, and rotation of the lumbar spine. Straight leg raise test was positive bilaterally, more on the left. There was decreased sensation along the outside of the left and foot. There was mild weakness of the gluteals, tibialis anterior evertors, quadriceps and adductors on the left. MRI of the lumbar spine dated January 26, 2013 showed spondylosis causing no significant spinal stenosis on L4-L5 and extrusion causing encroachment of the left subarticular recess with probable mass effect on the L5 nerve root; degenerative changes of sacroiliac joints and focal disc extrusion and facet disease at L3-L4; and at L5-S1, there was posterior disc bulge with focal HNP and facet disease causing no stenosis. Treatment to date has included medications, physical therapy, aqua therapy, chiropractic therapy, massage, home exercise program, activity modification, TENS, and total hip replacement. Utilization review, dated January 24, 2014, denied the request for Lidoderm 5% #30 with 1 refill because further research was needed to recommend this treatment for chronic neuropathic pain disorders. The request for Flector 1.3% #30 with 1 refill was also denied because there was little evidence to utilize topical NSAIDs for the hip and they are recommended for short-term use only.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION OF LIDODERM 5% #30 WITH 1 REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LIDODERM Page(s): 56-57.

Decision rationale: As stated on page 56-57 of the CA MTUS Chronic Pain Medical Treatment Guidelines, Lidoderm is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or and AED such as gabapentin or Lyrica). In this case, there was no documentation of a trial of first-line therapies mentioned above. The medical necessity has not been established. Therefore, the request for 1 PRESCRIPTION OF LIDODERM 5% #30 WITH 1 REFILL is not medically necessary.

1 PRESCRIPTION OF FLECTOR 1.3% #30 WITH 1 REFILL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-112.

Decision rationale: Pages 111-112 of CA MTUS Chronic Pain Medical Treatment Guideline state that topical NSAIDs, such as diclofenac (Flector patch), have been shown in meta analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Indications include osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. In this case, patient was given the medication since September 2013. However, medical records do not indicate relief of pain or functional benefits derived from its use. In addition, there was no mention of the patient having a diagnosis of osteoarthritis. The California MTUS does not support topical NSAIDs use for chronic spine and hip pain patients. The medication is recommended for short-term use only. Therefore, the request for 1 PRESCRIPTION OF FLECTOR 1.3% #30 WITH 1 REFILL is not medically necessary.