

Case Number:	CM14-0018622		
Date Assigned:	04/18/2014	Date of Injury:	06/17/2004
Decision Date:	08/04/2014	UR Denial Date:	02/05/2014
Priority:	Standard	Application Received:	02/13/2014

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 Occupational Medicine 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 58-year-old male who has filed a claim for low back pain associated with an industrial injury date of June 17, 2004. Review of progress notes indicates pain in the low back radiating to the right lower extremity, right foot, right knee, right leg, and right hand. There was complete relief of pain following right knee injection. The patient reports poor sleep quality, waking up often during the night, with excessive daytime sleepiness. The patient reports an increased consumption of alcohol to one beer and one mixed drink per day, and worsening of mood and symptoms of depression. Examination of the low back showed restricted range of motion, tenderness, muscle spasms, and positive straight leg raise test on the right. Examination of the right hand showed swelling over the right snuff box; and painful range of motion and tenderness over the thumb, index, and middle fingers. Examination of the right knee showed tenderness over the joint line with mild effusion. Examination of the right foot showed deformity, swelling, and restricted and painful range of motion of the toes. There was decreased motor strength of the right EHL, ankle dorsiflexors, and ankle plantarflexors; decreased sensation over the right lateral calf; and decreased ankle jerk reflex. Right knee x-ray dated July 24, 2013 showed near bone on bone osteoarthritis in the patellofemoral compartment, very mild degenerative changes in the medial and lateral compartments, and early osteophyte formation on the medial and lateral femoral condyles. Patient currently works full time. Treatment to date has included opioids, antiepilepsy drugs, NSAIDs, muscle relaxants, sedatives, Voltaren gel, TENS, physical therapy, acupuncture, chiropractic therapy, injections to the right knee and foot, injections to the low back, home exercises, and right wrist bracing. Utilization review from February 04, 2014 denied the requests for lidocaine 5% 700mg #30 as there was no indication for the use of this medication; Voltaren 1% #300 as there was no documentation of osteoarthritis;

Silenor 3mg #30 as long-term use is not recommended; and hydrocodone/APAP 10/325mg #60 as there was no documentation regarding its efficacy.

IMR ISSUES, DECISIONS AND RATIONALES

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

LIDOCAINE 5% 700MG #30: Upheld

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

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

Decision rationale: As stated on pages 56-57 in the CA MTUS Chronic Pain Medical Treatment Guidelines, Lidoderm may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants, or an AED such as gabapentin or Lyrica). In this case, although the patient has been started on Silenor and Topamax, there is no clear documentation of peripheral neuropathy to support the use of this medication. Therefore, the request for lidocaine 5% 700mg #30 was not medically necessary.

SILENOR 3MG #30: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : Antidepressants for chronic pain Page(s): 13-15. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Insomnia treatment.

Decision rationale: Pages 13-15 of CA MTUS Chronic Pain Medical Treatment Guidelines state that tricyclics are considered first-line agents for neuropathic pain, especially when accompanied by insomnia, anxiety, or depression. It is a possible option for non-neuropathic pain in depressed patients. According to ODG, sedating antidepressants can also be used to treat insomnia, however, there is less evidence to support their use. They may be an option in patients with coexisting depression. Patient has been on this medication since at least July 2013. Patient is taking this medication on an as-needed basis for sleep initiation and maintenance, and notes deeper sleep and less sedation during the day. The patient also suffers from adjustment disorder with depression, with worsening of mood and depressive symptoms. Continued use of this medication is necessary at this time, as it has been beneficial in managing the patient's sleep difficulties. Therefore, the request for Silenor 3mg #30 was medically necessary.

HYDROCODONE-ACETAMINOPHEN 10MG-325MG #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : Opioids, criteria for use; On-Going Management Page(s): 78-82.

Decision rationale: As noted on pages 78-82 of the CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Patient has been on this medication since at least July 2013. The patient takes this medication on an as-needed basis, around 0-3 tablets per day, depending on the severity of the pain. Urine drug screens have also been consistent. Also, this medication provides a tolerable level of pain for the patient to be able to increase functionality and continue working. Continuation of this medication is necessary at this time to provide ongoing pain relief and functional improvement. Therefore, the request for hydrocodone-acetaminophen 10mg-325mg #60 was medically necessary.

VOLTAREN 1% #300: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS Page(s): 112.

Decision rationale: As stated on page 112 in the CA MTUS Chronic Pain Medical Treatment Guidelines, Voltaren gel is indicated for relief of osteoarthritis pain in the joints that lend themselves to topical treatment which includes the ankles, elbows, feet, hands, knees, and wrist. Patient has been on this medication since September 2013. Right knee radiograph shows evidence of nearly bone on bone osteoarthritis. The patient recently received injections to the right knee, with complete relief of pain. At this time, use of a topical NSAID for right knee osteoarthritis is not necessary. Also, the requested quantity is not appropriate for a 30-day supply. Therefore, the request for Voltaren 1% #300 was not medically necessary.