

Case Number:	CM14-0131747		
Date Assigned:	08/20/2014	Date of Injury:	06/17/2003
Decision Date:	09/23/2014	UR Denial Date:	07/24/2014
Priority:	Standard	Application Received:	08/18/2014

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 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 66 year old male with a reported date of injury on 06/17/2003. The mechanism of injury was a fall. The diagnoses include chronic pain syndrome, thoracic spondylosis, cervical spondylosis, and lumbosacral spondylosis. The past treatments included medications, chiropractic treatment, massage therapy, and trigger point injections. The MRI of the lumbar spine on 12/28/2012 revealed facet arthropathy at L4-L5 and L5-S1. The surgical history included coronary stents on 03/06/2014. On 04/21/2014, the subjective complaints were mid back pain that radiates to his chest wall. The physical examination revealed a positive straight leg raise on the right and negative on the left. The medications included Flector patch, Percocet, Lyrica, Lidoderm, and Voltaren gel. The plan was to refill medications. The request for authorization form is dated 04/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm 5% once a day prn pain 30 days, #30 Refills 2: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 57-58.

Decision rationale: The request for Lidoderm 5%, #30, Refills 2 is not medically necessary. The California MTUS guidelines state Lidoderm patches 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). Additionally the guidelines state Lidoderm is only FDA approved for post-herpetic neuralgia and further research is needed to recommend this treatment for other chronic neuropathic pain disorders. The injured worker had chronic low back pain with radiating symptoms and is currently taking Lyrica; however, there is no documentation in regards to the effectiveness of Lyrica to support the use of Lidoderm. Additionally, the injured worker was not noted to have post-herpetic neuralgia and the guidelines state additional research is needed to support use of Lidoderm patches for other types of neuropathic pain. For these reasons, the request is not medically necessary.

Voltaren Gel 1% up to 4 grams per joint 4 times a day, tid rn pain 30 days qs, refills 2:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request for Voltaren Gel 1%, refills 2 is not medically necessary. The California MTUS guidelines state Voltaren Gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment. It has not been evaluated for treatment of the spine, hip or shoulder. The injured worker has chronic low back pain and use of Voltaren gel is not supported in the spine, hip or shoulder. As such, the request is not medically necessary.

Lyrica cap 100 mg tid 30 days, #90, refills 0: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTIEPILEPSY DRUGS (AEDS) Page(s): 19.

Decision rationale: The request for Lyrica cap 100 mg #90, refills 0 is not medically necessary. The California MTUS guidelines state in regards to Lyrica, after initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. The injured worker has chronic low back pain and has been on Lyrica at least since 02/26/2014. There is no specific documentation in regards to pain relief, improvement of function, or side effects incurred with the use of Lyrica. As such, the request is not medically necessary.