MAXIMUS Federal Services

Case Number:	CM14-0134885		
Date Assigned:	08/27/2014	Date of Injury:	08/06/2007
Decision Date:	09/29/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	08/21/2014

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 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 injured worker is a 45-year-old female who reported an injury 08/06/2007. The mechanism of injury was not provided within the medical records. The clinical note dated 07/09/2014 indicate a diagnoses of pain in the low back, sciatica, back ache, lumbar radiculopathy, lumbar degenerative disc disease, spinal stenosis without neurogenic claudication, degenerative joint disease, and pain in joint, pelvis, and thigh. The injured worker reported back pain in the right lower back area, described as aching and dull. She rated her pain 7/10. The injured worker reported the symptoms were alleviated by lying down and exacerbated by prolonged standing and prolonged walking. The injured worker reported pain severity was moderate. On physical examination of the lumbar spine, there was tenderness present at the right iliac crest with radiation throughout the right inguinal region. The injured worker had a positive Faber test. The injured worker's straight leg raise test was positive on the right. The injured worker's prior treatments included diagnostic imaging, surgery, and medication management. The injured worker's medication regimen included Lidoderm, Lexapro, and Flexeril. The provider submitted a request for Lidocaine patch and Celebrex. A Request for Authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Lidocaine 5% patch #30 (DOS 7/11/14): 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.

Decision rationale: The request for Retrospective request for Lidocaine 5% patch #30 (DOS 7/11/14) is not medically necessary. The California Chronic Pain Medical Treatment Guidelines state that transdermal compounds are largely experimental in use with few randomized controlled trials to determine efficiency or safety. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines indicate topical Lidocaine in the formulation of the dermal patch Lidoderm. No other commercially approved topical formulations of Lidocaine, whether creams, lotions or gels, are indicated for neuropathic pain. In addition, it was not indicated if the injured worker had tried and failed antidepressants or anti-convulstants. Moreover, the request does not indicate a frequency or quantity. Additionally, the medical records did not have a clinical note dated 07/11/2014. Furthermore, the provider did not indicate a rationale for the request. Therefore, the request for Retrospective request for Lidocaine 5% patch #30 (DOS 7/11/14) is not medically necessary.

Retrospective request for Celebrex 200mg 330 (DOS 7/11/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

Decision rationale: The request for retrospective request for Celebrex 200mg 330 (DOS 7/11/14) is not medically necessary. The CA MTUS guidelines recognize anti-inflammatories as the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. It was not indicated the injured worker had tried acetaminophen. In addition, the provider did not indicate a rationale for the request. Moreover, the clinical note dated 07/11/2014 was not provided within the medical records. Furthermore, the request does not indicate a frequency. Therefore, the request for Celebrex 200mg 330 (DOS 7/11/14) is not medically necessary.

Lidocaine 5% patch #30: 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.

Decision rationale: The request for Lidocaine 5% patch #30 is not medically necessary. The California Chronic Pain Medical Treatment Guidelines state that transdermal compounds are

largely experimental in use with few randomized controlled trials to determine efficiency or safety. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines indicate topical Lidocaine in the formulation of the dermal patch Lidoderm. No other commercially approved topical formulations of Lidocaine, whether creams, lotions or gels, are indicated for neuropathic pain. In addition, it was not indicated if the injured worker had tried and failed antidepressants or anti-convulstants. Moreover, the request does not indicate a frequency or quantity. Furthermore, the provider did not indicate a rationale for the request. Therefore, the request for Lidocaine 5% patch #30 is not medically necessary.

Celebrex 200mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

Decision rationale: The request for Celebrex 200mg #30 is not medically necessary. The CA MTUS guidelines recognize anti-inflammatories as the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. It was not indicated the injured worker had tried acetaminophen. In addition, it was not indicated if this was for a trial use or if the injured worker had utilized Celebrex. If so, there is lack of documentation of efficacy and functional improvement with the use of Celebrex. Moreover, the request does not indicate a frequency. Therefore, the request for Celebrex 200mg #30 is not medically necessary.