

Case Number:	CM14-0170932		
Date Assigned:	10/23/2014	Date of Injury:	06/30/1997
Decision Date:	12/02/2014	UR Denial Date:	09/22/2014
Priority:	Standard	Application Received:	10/16/2014

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 Emergency Medicine and is licensed to practice in New York. 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 61-year-old female who was injured on June 30, 1997. The patient continued to experience bilateral knee pain, neck, pain, and back pain. The patient has also been experiencing chest pain. Physical examination was notable for tenderness of the posterior and bilateral trapezius musculature, slight tenderness in the lower lumbar paravertebral muscles, and tenderness along the medial and lateral joint lines of both knees with subpatellar crepitation. Diagnoses included chronic pain syndrome, bilateral knee arthritis, status post carpal tunnel release, diabetes, obesity, and patellar fasciitis. Treatment included medications. Requests for authorization for Lidoderm patches 5% #60 with 2 refills, referral for cardiology evaluation and stress test, referral to an ophthalmologist for examination and prescription eyeglasses, and Motrin 800mg, #60 with 2 refills were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patches to apply q 12h #60 with two refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: Lidocaine is recommended for localized peripheral pain after the evidence of a trial for first-line therapy, such as an antidepressant or antiepileptic drug. It is only FDA approved for the treatment of post-herpetic neuralgia. The guidelines state that further research is needed to recommend this treatment for chronic neuropathic pain. Criteria for use of Lidoderm patches: a) Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology.(b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI (serotonin reuptake inhibitor) anti-depressants or an AED (antiepilepsy drug) such as gabapentin or Lyrica).(c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points.(d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale.(e) The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day).(f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks).(g) It is generally recommended that no other medication changes be made during the trial period.(h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued.(i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued.In this case the patient had been taking the medications since at least February 2014 and had not obtained analgesia. In addition the diagnosis of neuropathic pain is not supported by the documentation in the medical record. The request is not medically necessary.

Referral for cardiology evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7, Independent Medical Examination and Consultations regarding Referrals

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UpToDate: Diagnostic approach to chest pain in adults

Decision rationale: The most common etiologies of chest pain in primary care practice include musculoskeletal and gastrointestinal causes, followed by cardiac, psychiatric, pulmonary, and other causes. Any patient with a recent onset of chest pain who may be potentially unstable based upon history, appearance, or vital signs, should be transported immediately to an emergency department. The initial goal in the office evaluation of chest pain in stable individuals is to exclude acute coronary syndrome (ACS) and other potentially life-threatening conditions. This is usually accomplished with the history, physical examination, and certain ancillary studies (eg, ECG, chest radiograph, and further testing for ACS, pulmonary embolism, or aortic dissection as indicated). In this case the patient had experienced stable pattern of chest pain for several months. The patient had risk factors (diabetes, obesity) for heart disease, but was not experiencing acute coronary syndrome. Cardiology evaluation is not necessary unless cardiac disease is suspected or testing is positive. Medical necessity has not been established. The request for Cardiology evaluation is not medically necessary.

Referral to an ophthalmologist for examination, prescription eyeglasses: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7, Independent Medical Examination and Consultations regarding Referrals

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UpToDate: Diabetic retinopathy: Screening

Decision rationale: Patients with diabetes should have screening for diabetic retinopathy (DR) Screening must be performed by those with expertise and can be accomplished with dilated fundus examination or retinal photography. Patients with type 1 diabetes should have initiating screening three to five years after diagnosis. In patients with type 2 diabetes initial screening should occur soon after the time of diagnosis. In patients who are found to have retinopathy on initial screening examination, we suggest annual follow-up examinations. More frequent follow-up is necessary if retinopathy is progressing. Patients with macular edema (ME), severe nonproliferative retinopathy, or proliferative retinopathy should be closely followed by an ophthalmologist, who is experienced in the management of diabetic retinopathy. If there is no evidence of retinopathy on initial examination, less frequent examinations (every two to three years) may be adequate. In this case the patient had undergone ophthalmology examination in 2012. There was no evidence of ophthalmologic disease at that time. Follow up visit is appropriate, but the need for prescription glasses is not supported by the documentation in the medical record. The patient has no complaints of visual disturbance. The request is not medically necessary.

Motrin 800mg one tab b.i.d. #60 with two refills: 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 Pain interventions and Guidelines Page(s): 67-68.

Decision rationale: Motrin is ibuprofen a nonsteroidal anti-inflammatory drug (NSAID). Chronic Medical Treatment Guidelines state that "anti-inflammatory drugs are the traditional first line of treatment, but long term use may not be warranted". For osteoarthritis it was recommended that the lowest dose for the shortest length of time be used. It was not shown to be more effective than acetaminophen, and had more adverse side effects. Adverse effects for GI toxicity and renal function have been reported. Medications for chronic pain usually provide temporary relief. Medications should be prescribed only one at a time and should show effect within 1-3 days. Record of pain and function with the medication should be documented. In this case the patient had been receiving the medication since at least February 2014 and had not obtained analgesia. The duration of treatment increases the risk of adverse effects with little benefit. The request is not medically necessary.

Stress test: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7, Independent Medical Examination and Consultations regarding Referrals.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation UpToDate: Diagnostic approach to chest pain in adults

Decision rationale: The most common etiologies of chest pain in primary care practice include musculoskeletal and gastrointestinal causes, followed by cardiac, psychiatric, pulmonary, and other causes. Any patient with a recent onset of chest pain who may be potentially unstable based upon history, appearance, or vital signs, should be transported immediately to an emergency department. The initial goal in the office evaluation of chest pain in stable individuals is to exclude acute coronary syndrome (ACS) and other potentially life-threatening conditions. This is usually accomplished with the history, physical examination, and certain ancillary studies (eg, ECG, chest radiograph, and further testing for ACS, pulmonary embolism, or aortic dissection as indicated). In this case the patient had experienced stable pattern of chest pain for several months. The patient had risk factors (diabetes, obesity) for heart disease, but was not experiencing acute coronary syndrome. Outpatient stress testing is appropriate. Therefore the request for Stress Test is medically necessary.