

Case Number:	CM14-0173136		
Date Assigned:	10/23/2014	Date of Injury:	12/09/2009
Decision Date:	12/31/2014	UR Denial Date:	10/13/2014
Priority:	Standard	Application Received:	10/20/2014

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 Orthopedic Surgery, 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:

This is a 53 year of female with a work related history dated December 9, 2009. The physician's documentation dated September 19, 2014, the worker described generalized body pain in the neck, back, shoulder and fingers and rated six to nine, moderate to severe, constant, frequent with weakness and aching soreness. Physical exam revealed active range of motion of the lumbar spine was decreased in all ranges, active range of motion of the lumbar spine also decreased in all ranges. The right wrist was documented with positive crepitus/click, decreased range of motion with ulnar deviation. Diagnoses documented at this visit included rotator cuff syndrome of shoulder, old bucket handle tear of medial meniscus, lumbar pain, lumbosacral neuritis, displacement of lumbar intervertebral disc and chondromalacia of patella. Plan of care included a request for Neurontin twice per day and Lidoderm patches. Per the utilization review dated October 13, 2014, the request for Neurontin 600mg, 60 count and the Lidoderm patch five percent, 90 count were both non-certified. The Neurontin was non-certified with the rationale that the medical record did not include an in-depth history, past history or orthopedic physical examination. There was also no summary of prior treatment and no summarization of diagnostic studies. There was also no clear documentation of diabetic neuropathy, post-therapeutic neuralgia or neuritis therefore the documentation did not support the medical necessity for the request. The Lidoderm was non-certified stating there was no quantitative objective clinical information, no history of use of this modality or the workers response to use. The Lidoderm patches were documented as not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 600 MG Quantity: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (gabapentin). Within the medical information available for review, there is documentation of diagnoses of rotator cuff syndrome of shoulder, old bucket handle tear of medial meniscus, lumbar pain, lumbosacral neuritis, displacement of lumbar intervertebral disc and chondromalacia of patella. However, there is no documentation of neuropathic pain. Therefore, based on guidelines and a review of the evidence, the retrospective request for Neurontin 600 MG Quantity: 60 are not medically necessary.

Lidoderm Patch 5 Percent Quantity: 90: Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain after there has been evidence that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed, as criteria necessary to support the medical necessity of a lidocaine patch. Within the medical information available for review, there is documentation of diagnoses of rotator cuff syndrome of shoulder, old bucket handle tear of medial meniscus, lumbar pain, lumbosacral neuritis, displacement of lumbar intervertebral disc and chondromalacia of patella. However, there is no documentation of neuropathic pain and that a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica) has failed. Therefore, based on guidelines and a review of the evidence, the request for Lidoderm Patch 5 Percent Quantity: 90 are not medically necessary.