

Case Number:	CM14-0022769		
Date Assigned:	06/11/2014	Date of Injury:	10/11/2000
Decision Date:	07/15/2014	UR Denial Date:	02/19/2014
Priority:	Standard	Application Received:	02/24/2014

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 Minnesota. 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 60-year-old male who reported an injury on 10/11/2000. The mechanism of injury was not provided within the medical records. The clinical note dated 05/19/2014 indicated diagnoses of thoracolumbar spine sprain with left sacroiliac sprain and left leg radiculitis, L4-5 left-sided disc protrusion greater than L5-S1 with stenosis, and multilevel bilateral facet hypertrophy per MRI study dated 11/14/2013 and minimal to light interval changes from the MRI scan of 07/15/2006. The injured worker reported 50% to 60% relief in his low back pain and symptoms. He reported pain increased with prolonged sitting, standing, walking, bending, and lifting and decreased with rest, medication, home exercise program, and electrical muscle stimulation unit. On physical examination of the lumbar spine, the injured worker reported muscle spasms; there was tenderness to palpation over the paravertebral musculature and lumbosacral junction. The range of motion of the lumbar spine revealed flexion of 42 degrees, extension of 14 degrees, right side bending of 16 degrees, and left side bending of 16 degrees. The injured worker's prior treatments have included diagnostic imaging, epidural steroid injections, and medication management. The provider submitted request for Lidoderm patch 5% QTY: 30.00 and [REDACTED]. A request for authorization dated 01/14/2014 was submitted for Lidoderm patch 5% QTY: 30.00; however, a rationale was not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

LIDODERM PATCH 5% QTY 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

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

Decision rationale: The request for Lidoderm Patch 5% Qty 30.00 is non-certified. The California Chronic Pain Medical Treatment Guidelines states Lidoderm has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. The documentation submitted did not indicate the injured worker had findings that would support he was at risk for diabetic neuropathy. In addition there was lack of evidence of neuropathic pain. Furthermore, the request did not indicate a frequency for the medication. Therefore, the request for Lidoderm patches 5% QTY: 30.00 is not medically necessary.

██████████ **QTY 1.00:** Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Heart, Lung, And Blood Institute. Clinical Guidelines On The Identification, Evaluation, And Treatment Of Overweight And Obesity In Adults--Executive Summary.

Decision rationale: The request for ██████████ is non-certified. The clinical guidelines indicate dietary modification, weight loss or participation in formal weight reduction programs. There was lack of documentation of prior dietary modifications or participation in formal weight reduction programs. In addition, the request did not include the duration of frequency of the proposed program. Furthermore, the provider did not indicate a rationale for the request. Moreover, the documentation submitted did not indicate the injured worker's weight to justify the request. Therefore, the request for ██████████ QTY: 1.00 is not medically necessary.