

Case Number:	CM14-0023402		
Date Assigned:	06/11/2014	Date of Injury:	02/13/2010
Decision Date:	12/15/2014	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	02/25/2014

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 Occupational 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:

This is a 40-year-old male with a 2/13/10 date of injury. The patient reported an injury while working as a fieldworker that involved multiple facial and skull fractures, including his right eye being pulled from its socket. According to a progress report dated 1/20/14, the patient rated his pain as an 8/10 and that his pain has ranged from 7-10/10 since his last visit. Objective findings: tenderness and tightness over the trapezius and lumbosacral area, hypoesthesia and dysesthesia in the posterolateral aspects of the left arm and posteriorly in the left leg down to the lateral foot. Diagnostic impression: cervical degenerative disc disease, cervical radiculopathy, lumbar degenerative disc disease, lumbar lumbar facet osteoarthritis. Treatment to date: medication management, activity modification, surgeries. A UR decision dated 2/4/14 denied the requests for Lidocaine 5% and hydrocodone-APAP 10/325mg. Regarding lidocaine, there is no documentation of neuropathic pain symptoms, physical exam findings indicative of radiculopathy, or failed first-line therapy, or documented functional improvement from the previous use of this topical agent. Regarding hydrocodone, there is no VAS quantification of pain or documented symptomatic or functional improvement from its long-term usage.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidocaine 5% (700MG) #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine Patch Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter - Lidoderm

Decision rationale: CA MTUS states that topical lidocaine 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). ODG states that Lidoderm is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. The guidelines state that for continued use of Lidoderm patches, the area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day). The documentation provided does not include this information. In addition, there is no discussion in the reports regarding the patient failing treatment with a first-line agent such as gabapentin. Furthermore, there is no documentation that the patient is unable to take oral medications. Therefore, the request for Lidocaine 5% (700mg) #60 was not medically necessary.

Hydrocodone-APAP 10-325mg #45: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, in the reports reviewed, there is no documentation of significant pain reduction or improved activities of daily living. Guidelines do not support the continued use of opioid medications without documentation of functional improvement. In addition, there is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, urine drug screen, or CURES monitoring. Therefore, the request for Hydrocodone-APAP 10-325MG #45 was not medically necessary.