

Case Number:	CM14-0041183		
Date Assigned:	07/09/2014	Date of Injury:	05/09/2001
Decision Date:	08/27/2014	UR Denial Date:	03/18/2014
Priority:	Standard	Application Received:	04/07/2014

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 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 an 80-year-old female who reported an injury on 05/09/2001. Diagnoses included lumbar/lumbosacral disc degenerative. The mechanism of injury was noted to be the injured worker had a trip and fall. Prior surgeries were noncontributory. The injured worker's medication history included Lidoderm patches and Norco 10 mg as of 2008. The documentation of 02/20/2014 revealed the injured worker had back pain radiating from the low back down to both legs and a lower backache. The injured worker has previously received injections which were beneficial. The injured worker had decreased range of motion. The injured worker had a positive right Faber test and tenderness over the sacroiliac spine. The treatment plan included an x-ray of the lumbar spine, current medications as current doses, a rolling walker to assist with ambulation and transforaminal epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm 5% Patch #60 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Lidoderm patches. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-Pain (Chronic).

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

Decision rationale: The California MTUS guidelines indicate that topical Lidocaine (Lidoderm) 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). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. No other commercially approved topical formulations of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant nonadherence to guideline recommendations. The documentation indicated the injured worker had neuropathic pain. The documentation indicated the injured worker had utilized the medication since at least 2008. There was a lack of documentation indicating a necessity for 1 refill without re-evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for lidoderm 5% patch #60 with 1 refill is not medically necessary.

Norco 10/325 #60 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for ongoing management, Chronic pain Page(s): 78, 60.

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of chronic. There should be documentation of objective functional improvement, and objective decrease in pain and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of the above criteria. The clinical documentation indicated the injured worker had been utilizing the medication since at least 2008. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating a necessity for 1 refill without re-evaluation. Given the above, the request for Norco 10/325 #60 with 1 refill is not medically necessary.