

Case Number:	CM14-0051657		
Date Assigned:	07/14/2014	Date of Injury:	09/08/2007
Decision Date:	08/29/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	04/18/2014

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 a 58-year-old female who reported an injury on 09/08/2007. The mechanism of injury was a lifting injury. Prior surgical intervention included a lumbar discectomy. Prior medications included Ambien, Xanax, Percocet, and Flexeril, as well as Lidoderm patches. The medications were in use since at least 09/2013. The documentation of 03/04/2014 revealed the injured worker had muscle spasms. The physical examination and documentation was difficult to read as it was noted to be of poor fax quality. The documentation indicated the injured worker was being monitored through urine drug screens. The medications were noted to include Percocet, Xanax, Flexeril, Ambien, and Lidoderm. The diagnoses were noted to include chronic pain symptoms, multifactorial, status post cervical fusion, and there was an inability to read other diagnoses. The treatment plan included Lidoderm patches 5% #1 on top of right elbow 12 hours on 12 hours off refills times 3, Ambien 10 mg #1 by mouth at bedtime as needed replacing Silenor 3 mg, Percocet 7.5/325 mg 1 3 times a day to 4 times a day as needed #120, Xanax 0.5 mg 1 by mouth every day to twice a day as needed #40, and Flexeril 10 mg #1 every day to twice a day.

IMR ISSUES, DECISIONS AND RATIONALES

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

(Lidoderm) Lodo Pads 5.0% #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LIDODERM Page(s): 56.

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 was difficult to read. The documentation indicated the injured worker had utilized the medication since at least late 2013. There was a lack of documentation of objective functional benefit and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for (Lidoderm) Lodo Pads 5.0% #30 is not medically necessary and appropriate.

Oxycodone Acetaminophen 10-325mg #110: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OXYCODONE/ACETAMINOPHEN OPIOD USE Page(s): 92, 77-78.

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

Decision rationale: The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an 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 indicated the injured worker had utilized the medication since at least 09/2013. There was a lack of legible documentation of the above criteria. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Oxycodone Acetaminophen 10/325 mg #110 is not medically necessary and appropriate.

Alprazolam .5mg #40: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BENZODIAZEPINES Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The California MTUS Guidelines do not recommend benzodiazepines as a treatment for injured workers with chronic pain for longer than 3 weeks due to a high risk of psychological and physiological dependence. The clinical documentation submitted for review indicated the injured worker had been utilizing the medication for an extended period of time.

The objective functional benefit was not noted. There was a lack of documentation of exceptional factors to warrant non-adherence to Guideline recommendations. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Alprazolam .5 mg #40 is not medically necessary and appropriate.