MAXIMUS Federal Services

Case Number:	CM14-0058798		
Date Assigned:	07/09/2014	Date of Injury:	07/17/2006
Decision Date:	10/06/2014	UR Denial Date:	04/03/2014
Priority:	Standard	Application Received:	04/29/2014

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 & Rehabilitation, and is licensed to practice in Louisiana. 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 patient is a 53 year old male who sustained an industrial injury to his low back in the course of his employment on 07/17/2006. The mechanism of injury is unknown. Progress report dated 07/10/2012 documented the patient to have complaints of low back pain with radiation down his legs on the left side with associated weakness, numbness and tingling. Objective findings on exam revealed lumbar flexion is 45 degrees; extension is 15 degrees with pain and lateral tilting is 10 degrees. Rotation is 70% of normal. There is hypertonicity at paraspinals from L2 to S1. Heel walking and toe walking is very painful. Straight leg raise is positive at 40 degrees. Dorsiflexion of the foot on the left increases his pain at posterior leg. He is diagnosed with lumbosacral pain with disc disease, status post intervention with laminectomy at three levels and with apparently abnormalities by MRI (this report is not available for review). He has a radicular component by exam and SI root involvement. His treatment plan included Voltaren Gel 1% #30 and Lidoderm patches 5%. Prior utilization review dated 04/03/2014 states the request for Lidoderm patches 5% #60 is denied as it is not recommended as a first line treatment and is only approved for postherpetic neuralgia; and Voltaren gel 1% 100gm x 3 is not recommended as there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patches 5% #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics; Lidoderm (lidocaine patch) Page(s): 111-113; 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Topical Analgesics

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Lidoderm patches are recommended for localized peripheral pain after there has been evidence of a trial of first line therapy. Further research is needed to recommend this treatment of chronic neuropathic pain other than post-herpetic neuralgia. There is a lack of supporting documentation for the use of this treatment therefore, this request is not medically necessary at this time.

Voltaren gel 1% 100 gm x 3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs (non-steroidal anti-inflammatory agents).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Topical Analgesics

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Voltaren Gel is considered a topical non-steroidal anti-inflammatory agent recommended for the use of this type of medication for chronic musculoskeletal pain. Topical NSAIDs are indicated for short term treatment of osteoarthritis and tendinitis, in particular, that of the knee, elbow, or other joints and are not recommended for spine, hip, or shoulder. There is no supporting documentation that the use of Voltaren Gel will be beneficial in this case for low back pain. The request for this treatment is not medically necessary at this time.