

Case Number:	CM14-0064961		
Date Assigned:	07/11/2014	Date of Injury:	05/08/2008
Decision Date:	08/21/2014	UR Denial Date:	04/28/2014
Priority:	Standard	Application Received:	05/07/2014

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 Internal Medicine, Pulmonary Disease 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 35-year-old female who reported an injury on 05/08/2008. The mechanism of injury was from repetitive heavy lifting. The diagnoses include abnormality of gait, degeneration of lumbar, lumbosacral intervertebral disc, thoracic/lumbosacral neuritis or radiculitis. Previous treatments included medication and steroid injections. Within the clinical note dated 07/08/2014, it was reported the injured worker complained of back pain. She rated her pain 8/10 in severity. Upon the physical examination, the provider noted tenderness to palpation of the lumbar paraspinal muscles bilaterally. There was decreased active range of motion with forward flexion at 20 degrees, and extension at 5 degrees. The provider indicated motor strength was 5/5, and sensory was grossly intact. The injured worker had tenderness to palpation of the left gluteal and hip abductor region. The provider noted the injured worker had muscle spasms in the left gluteal region just below the trochanter, greater. The request submitted is for Gralise, Skelaxin, and Lidoderm patch. However, rationale was not provided for clinical review. The Request for Authorization was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gralise OR 600mg, #540: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Anti-epilepsy drugs (AEDs) Page(s): 18-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49.

Decision rationale: The request for Gralise OR 600 mg #540 is not medically necessary. Within the clinical note dated 07/08/2014, it was reported the injured worker complained of back pain. She rated her pain 8/10 in severity. The California MTUS Guidelines note gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. There is a lack of documentation indicating the efficacy of the medication, as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. There is a lack of documentation indicating the injured worker was treated for diabetic painful neuropathy. Additionally, the injured worker has been utilizing the medication since 09/2011. Therefore, the request is not medically necessary.

Skelaxin 800mg, #360: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 61, 65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63, 64.

Decision rationale: The request for Skelaxin 800 mg #360 is not medically necessary. Within the clinical note dated 07/08/2014, it was reported the injured worker complained of back pain. She rated her pain 8/10 in severity. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. There is a lack of documentation indicating the efficacy of the medication, as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker has been utilizing the medication since at least 09/2011, which exceeds the guidelines' recommendation of short-term use of 2 to 3 weeks. Therefore, the request is not medically necessary.

Lidoderm 5% patch, #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

Decision rationale: The request for Lidoderm 5% patch #180 is not medically necessary. Within the clinical note dated 07/08/2014, it was reported the injured worker complained of back pain. She rated her pain 8/10 in severity. The California MTUS Guidelines note topical NSAIDs are

recommended for use of osteoarthritis and tendonitis, in particular, that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short-term use of 4 to 12 weeks. There is little evidence to utilize topical NSAIDs for the treatment of osteoarthritis of the spine, hip, or shoulder. The guidelines note Lidoderm is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Lidoderm is also used off-label for diabetic neuropathy. There is a lack of documentation indicating the injured worker has tried and failed on antidepressants or anticonvulsants. The injured worker has been utilizing the medication for an extended period of time, since at least 09/2011, which exceeds the guidelines' recommendation of short-term use of 4 to 12 weeks. There is a lack of documentation within the medical records indicating the efficacy of the medication, as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.