

Case Number:	CM14-0088631		
Date Assigned:	07/23/2014	Date of Injury:	09/21/1998
Decision Date:	09/18/2014	UR Denial Date:	04/21/2014
Priority:	Standard	Application Received:	05/13/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 67-year-old female who reported an injury on 09/21/1998, secondary to a fall. The current diagnoses include post lumbar laminectomy syndrome and lumbar disc disorder. The injured worker was evaluated on 06/05/2014 with complaints of persistent pain. The injured worker reported 4/10 pain with the current medication regimen and 8/10 pain without the current medication regimen. Current medications include Provigil 200 mg, Dilaudid 4 mg, and Lidoderm 5% patch. The injured worker also utilizes an intrathecal pump with Hydromorphone, Clonidine, and Bupivacaine. Physical examination on that date revealed restricted lumbar range of motion, positive straight leg raising on the left, SI joint tenderness, diminished motor strength in the lower extremities, and decreased sensation over the inferior aspect of the bilateral feet. Treatment recommendations at that time included continuation of the current medication regimen. There was no request for authorization form submitted on the requesting date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Provigil 200 Mg Tablet Sig: 1 Tablet by Mouth (Po) BID (Q8am and Q Noon): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Provigil Page(s): 56-57, 79-81. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Modafinil (Provigil®).

Decision rationale: The Official Disability Guidelines do not recommend Provigil to solely counteract sedation effects of narcotics until after first considering reducing excessive narcotic prescribing. Therefore, the current request cannot be determined as medically appropriate in this case. The injured worker has continuously utilized this medication since 08/2012. There is no documentation of an attempt to reduce excessive narcotic prescribing. Based on the clinical information received and the Official Disability Guidelines, the request is not medically appropriate.

Lidoderm 5% Patch (700mg Patch) Sig: Apply for 12 Hours per day as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The California MTUS Guidelines state Lidocaine is indicated for neuropathic pain or localized peripheral pain after there has been evidence of a failure of first-line treatment with antidepressants and anticonvulsants. As per the documentation submitted, the injured worker has continuously utilized this medication since 08/2012. There is no documentation of objective functional improvement. There is also no mention of a failure to respond to first-line oral medication prior to the initiation of a topical analgesic. As such, the request is not medically appropriate.

Dilaudid 4 Mg Tablet Sig: Take 1 Tablet Three Times Daily (TID) As Needed (PRN) (DAW): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81, 79-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has utilized this medication since 08/2012. There is no documentation of objective functional improvement. Therefore, the ongoing use of this medication cannot be determined as medically appropriate in this case.