

Case Number:	CM14-0094263		
Date Assigned:	07/25/2014	Date of Injury:	08/16/2007
Decision Date:	08/28/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	06/20/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 52 year old female who was injured on 08/16/07. There is no documentation of mechanism of injury. Prior treatment included radiofrequency neurotomy, aquatic therapy, and medications. The most recent progress note submitted for review is dated 06/24/14 the injured worker was complaining of low back pain and left hip pain. The procedure on 06/09 did help with her pain it was a left intraarticular hip injection. The injured worker had almost 100% relief of pain immediately and continues to have 90% relief of left hip pain. The injured worker feels more mobile, no longer limping and has more endurance. The injured worker has been able to do chores like dishes, vacuuming, sewing, and cooking which she has not been able to do for years. Physical examination noted lumbar range of motion, improve the ability to extend and rotate spine. The injured worker has improved left hip discomfort. Range of motion of lower extremities is within normal limits, improve range of motion of hip without pain. Diagnoses include left lumbar facet pain and left piriformis syndrome. There is a request for orthopedic evaluation of her left hip. Prior utilization review dated 06/13/14 the Lidocaine was denied. Methocarbomyl and Oxycodone was modified for tapering. In review of medical records, visual analog pain scale scores (VAS) were consistent 5-7 on a scale of 0 to 10 although there was no recorded VAS without medication and with medication. There is no documentation of functional improvement other than after her injections she was much more functional.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidocaine 5% (700 mg) Quantity: 30: Upheld

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

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

Decision rationale: The request for Lidocaine 5% (700 mg) Quantity: 30 is not medically necessary. The current evidence based guidelines do not support the request. Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. There is no clinical documentation submitted for review that reveals neuropathy. Therefore medical necessity has not been established.

Methocarbamol 750 mg Quantity: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for pain Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Guidelines Muscle relaxants (for pain).

Decision rationale: The request for Methocarbamol 750 mg Quantity: 90 is not medically necessary. The clinical documentation submitted for review as well as current evidence based guidelines do not support the request. Visual analog pain scale (VAS) scores were consistent 5-7 on a scale of 0 to 10 although there was no recorded VAS without medication and with medication. There is no documentation of functional improvement other than after injections she was much more functional. Recommend non-sedating muscle relaxants with caution as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Therefore medical necessity has not been established.

Oxycodone HCL 15 mg Quantity: 180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, opioid's.

Decision rationale: The request for Oxycodone HCL 15 mg Quantity: 180 is not medically necessary. The clinical documentation submitted for review does not support the request. Visual analog pain scale (VAS) scores were consistent 5-7 on a scale of 0 to 10 although there was no recorded VAS without medication and with medication. There is no documentation of functional improvement other than after injections the injured worker was much more functional. Prior utilization review dated 06/13/14 was modified to initiate weaning. As such medical necessity has not been established. However, these medications cannot be abruptly discontinued due to withdrawal symptoms, and medications should only be changed by the prescribing physician.