

Case Number:	CM14-0191856		
Date Assigned:	11/25/2014	Date of Injury:	05/05/2006
Decision Date:	01/12/2015	UR Denial Date:	11/07/2014
Priority:	Standard	Application Received:	11/17/2014

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 Family Practice 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:

This is a 61 year old female who sustained a work related injury to the left knee on 5/05/2006 while lifting a large dog. She underwent left knee arthroscopic surgery with meniscectomy. As a result of the injured left knee and delay in treatment she injured her right knee and lower back and underwent a right knee total arthroplasty. Per the Primary Treating Physician's Progress Report dated 8/20/2014, the injured worker reported low back pain and bilateral lower extremity pain with radiation down the posterior aspect of both lower extremities. She reported weakness resulting in falls and an increase in pain since the last visit. She also reported bilateral knee pain, neck pain and right shoulder pain with tingling in both hands. She has an inferential stimulator, back brace and knee braces. Physical Examination revealed tenderness in the midline of the lower lumbar spine and over the L2 vertebral body. There is a sensory deficit in the right lower extremity; motor functions of the lower extremities were within normal limits. Magnetic resonance imaging (MRI) of the lumbar spine was described as revealing multi-level degenerative changes including a compression fracture at L2 and other degenerative changes throughout the lumbar region. Diagnoses included lumbar degenerative disc disease, lumbar compression fracture and bilateral knee pain. The plan of care includes continuation of current care including pain medications, back brace, inferential stimulator and TENS unit, and physical therapy. On 11/07//2014, Utilization Review non-certified a prescription for Lidoderm #90 with one refill, Voltaren Gel, #5 tubes with one refill, and modified a prescription for Cymbalta #30 with 1 refill based on lack of medical necessity. The Chronic Pain Medical Treatment Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm #90 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine Page(s): 111, 112, 15.

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

Decision rationale: According to the MTUS guidelines, topical analgesics are recommended as an option as indicated below. They are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Lidocaine is 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). Lidoderm has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. In this case, the claimant did not have the above diagnoses. Long-term use of topical analgesics such as Lidoderm patches are not recommended. The request is not medically necessary.

Voltaren Gel #5 tubes 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111, 112, 15.

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

Decision rationale: According to the MTUS guidelines, topical analgesics are recommended as an option as indicated below. They are largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Although Voltaren gel is approved for arthritis of the knees, in this case, there was not a diagnosis of arthritis. In addition, the response to the use of the gel was not specified prior to requesting an additional refill. The request is not medically necessary.

Cymbalta #30 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13-14.

Decision rationale: Cymbalta is an SNRI antidepressant. Per guidelines, antidepressants are an option, but there are no specific medications that have been proven in high quality studies to be efficacious for treatment of lumbosacral radiculopathy. SSRIs have not been shown to be effective for low back pain (there was not a significant difference between SSRIs and placebo) and SNRIs have not been evaluated for this condition. The continued use is not supported by any evidence and is not medically necessary.