

Case Number:	CM15-0004591		
Date Assigned:	02/10/2015	Date of Injury:	02/28/2003
Decision Date:	04/03/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/09/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 47-year-old male who reported an injury on 02/28/2003. His diagnoses include left shoulder pain, chronic severe traumatic arthritis of the left shoulder, chronic low back pain, chronic pain syndrome with neuropathic symptoms, anxiety, and depression. His surgeries included a left shoulder total joint replacement on 10/24/2014 and a lumbar fusion with subsequent hardware removal. His treatments have included pain medication, physical therapy, and a TENS unit. The progress note dated 01/05/2015 documented the injured worker had complaints of significant pain and restricted range of motion in his left shoulder. He stated the muscles in his left shoulder were weak and he was having difficulty with insomnia. Trazodone had not been beneficial for him. His medications included Norco 10/325 mg, ibuprofen 800 mg, gabapentin 300 mg, omeprazole 20 mg, Pristiq 50 mg, and Lidoderm patch 5%. His physical exam documented tenderness to the bilateral lumbar paraspinous muscles from L1 through S1. He had 1+ muscle spasms and a negative twitch response. Lumbar spine range of motion was measured at flexion at 50 degrees, extension at 10 degrees, right lateral flexion at 15 degrees, and left lateral flexion at 15 degrees. He had a positive straight leg raise on the left at 40 degrees.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm Patches 5% #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation California Chronic Pain Medical Treatment Guidelines.

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

Decision rationale: The request for Lidoderm Patches 5% #90 is not medically necessary. The California MTUS Guidelines state that indications for the use of lidocaine include neuropathic pain. Recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Nondermal patch formulations are generally indicated as local anesthetics and antipruritics. There is a lack of documentation regarding the effectiveness of the Lidoderm 5% patches. The request does not include instructions on placement of the patches and timing of patches. Therefore, the request for Lidoderm Patches 5% #90 is not medically necessary.

Trazodone 50MG #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Insomnia Treatment.

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

Decision rationale: The request for Trazodone 50MG #60 is not medically necessary. The California MTUS Guidelines state antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006). Tricyclics are generally considered a first line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. (Saarto- Cochrane, 2005). Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. There is a lack of documentation regarding effectiveness of the trazodone for neuropathic pain. On assessment, the injured worker stated the trazodone had not been beneficial. The request does not include dosing information. This medication is recommended for weaning purposes. The request for Trazodone 50MG #60 is not medically necessary.