

<b>Case Number:</b>	CM15-0101699		
<b>Date Assigned:</b>	06/04/2015	<b>Date of Injury:</b>	01/13/2009
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	05/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2015

### 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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

### 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 59-year-old male, with a reported date of injury of 01/13/2009. The diagnoses include low back pain, status post L2-S1 lumbar fusion, status post lumbar hardware removal, and status post lumbar fusion, low back strain with disc herniation, lumbar postlaminectomy syndrome, lumbar radiculopathy, and lumbar disc degeneration. Treatments to date have included NSAIDs (non-steroidal anti-inflammatory drugs), oral medications, physical therapy, work modifications, x-rays of the lumbar spine, MRIs of the lumbar spine which showed chronic degenerative disc and facet changes, lumbar fusion of L2-S1, right paracentral disc protrusion at T12-L1, and posterior disc protrusion at L1-L2, caudal epidural steroid injection on 06/15/2011, with minimal relief for three weeks, pedicle screw injection at the S1 level bilaterally on 11/02/2011, lumbar fusion hardware removal on 02/06/2011, electrodiagnostic studies of the bilateral lower extremities which showed left L5-S1 radiculopathy, lumbar fusion extension on 08/19/2013, spinal cord stimulator trial on 03/11/2015, which resulted in 50% pain improvement, and spinal cord stimulator implantation on 04/16/2015. The progress report dated 05/06/2015 indicates that the injured worker was there to follow-up on his low back pain. It was noted that he had failed conservative treatments. The injured worker reported a tingling sensation to the bilateral legs and feet with activation of the spinal cord stimulator. He had been having issues programming the stimulator as three antennas had failed. The physical examination showed a healed incision scar to the lumbar spine, negative seated straight leg raise test, flexes to touch below the knees, 1+ bilateral patellar reflex, no spasticity, and slowed antalgic gait. The treating physician requested Meloxicam 15mg #30, with five refills and Lidoderm patch 5% #30, with five refills.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm patch 5% Qty 30 with 5 refills, apply 12 hrs on and 12 hrs off:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 112 of 127.

**Decision rationale:** Regarding request for topical lidoderm, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the first line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Additionally, there is no documentation of analgesic effect or objective functional improvement because of the currently prescribed lidoderm. Finally, there is no documentation of localized peripheral pain as recommended by guidelines. As such, the currently requested lidoderm is not medically necessary.

**Meloxicam 15 mg Qty 30 with 5 refills, 1 time daily:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs (NSAIDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 67-69 of 127.

**Decision rationale:** Regarding the request for Meloxicam, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Meloxicam is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Meloxicam is not medically necessary.