

Case Number:	CM15-0186398		
Date Assigned:	09/28/2015	Date of Injury:	09/08/2011
Decision Date:	11/12/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	09/22/2015

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 55 year old female, who sustained an industrial injury on 9-8-11. The injured worker is being treated for degenerative lumbar lumbosacral intervertebral disc disease, sprain-strain of thoracic region, sprain-strain of lumbar region and enthesopathy of hip region. Treatment to date has included topical Voltaren gel and Lidoderm patch, oral medications including Tramadol (used only if Voltaren is not effective), lumbar injections, facet injections, trigger point injections and activity modifications. On 9-8-15, the injured worker complains of midline lumbosacral pain and achy burning rated 5 out of 10 and left hip pain for 7 months described as burning and felt to be radiating from lumbar spine, but not associated with radicular complaints; with medications, she is able to manage her daily activity. Physical exam performed on 9-8-15 revealed tenderness to palpation over the interspinous processes of the lower lumbar spine with mild paracentral tenderness, asymmetric iliac crest height and painful range of lumbar range of motion and a normal gait. A request for authorization was submitted on 9-9-15 for Voltaren 1% topical gel #3, Lidoderm 5% adhesive patches #20 with 2 refills and one-quarter inch left heel lift. On 10-2-15 a request for Voltaren gel 2-4 grams with 3 refills, Lidoderm 5% #30 with 2 refills and one quarter inch left heel lift were non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1 Percent 2-4 Grams with 3 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Based on the 09/08/15 progress report provided by treating physician, the patient presents with midline lumbosacral and left hip pain. The request is for Voltaren Gel 1 Percent 2-4 Grams with 3 Refills. Patient's diagnosis per Request for Authorization form dated 09/09/15 includes degeneration lumbar-lumbosacral intervertebral disc, sprain/strain thoracic and lumbar regions, and enthesopathy hip region. Physical examination of the lumbar spine on 09/08/15 revealed tenderness to palpation over the interspinous processes of the lower lumbar spine with mild paracentral tenderness, asymmetric iliac crest height and painful range of motion. Treatment to date has included imaging studies, injections, activity modifications and medications. Patient's medications include Tramadol, Voltaren gel and Lidoderm patch. The patient is on modified duty working full-time, per 07/31/15 report. MTUS Guidelines, Topical Analgesics NSAIDs Section, page 111 states that topical NSAIDs are supported for peripheral joint arthritis/tendinitis type of problems, mostly for short term. Regarding topical NSAIDs MTUS also states, "Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Per 09/08/15 report, treater states the patient is "primarily using Voltaren gel on a daily basis to manage the symptoms...with medications able to manage her daily activity, recover while resting and improves her work tolerance." However, MTUS specifically states, "There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder." In this case, the patient does not present with peripheral joint osteoarthritis/tendinitis problems for which topical NSAIDs are indicated. This request is not in accordance with guidelines. Therefore, the request is not medically necessary.

Lidoderm 5 Percent 1 Daily #30 with 2 Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Lidoderm (lidocaine patch).

Decision rationale: Based on the 09/08/15 progress report provided by treating physician, the patient presents with midline lumbosacral and left hip pain. The request is for Lidoderm 5 Percent 1 Daily #30 with 2 Refills. Patient's diagnosis per Request for Authorization form dated 09/09/15 includes degeneration lumbar-lumbosacral intervertebral disc, sprain/strain thoracic and lumbar regions, and enthesopathy hip region. Physical examination of the lumbar spine on 09/08/15 revealed tenderness to palpation over the interspinous processes of the lower lumbar

spine with mild paracentral tenderness, asymmetric iliac crest height and painful range of motion. Treatment to date has included imaging studies, injections, activity modifications and medications. Patient's medications include Tramadol, Voltaren gel and Lidoderm patch. The patient is on modified duty working full-time, per 07/31/15 report. MTUS Guidelines pages 56 and 57, Lidoderm (Lidocaine patch) section states, "topical lidocaine may be 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)." MTUS Page 112, for Topical Analgesics, also states, "Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain." When reading ODG guidelines, chapter 'Pain (Chronic)' and topic 'Lidoderm (Lidocaine patch)', it specifies that lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. Per 09/08/15 report, treater states the patient is "primarily using Voltaren gel on a daily basis to manage the symptoms...Lidoderm one to 2 times per month, used at night when Voltaren is ineffective assist with initiation and maintenance of sleep and recovery...with medications able to manage her daily activity, recover while resting and improves her work tolerance." However, MTUS guidelines state that Lidocaine patches are appropriate for localized peripheral neuropathic pain. This patient presents with axial spine lumbosacral and hip pain. There is no documentation of other complaints for which this medication would be considered appropriate. Furthermore, there is no documentation of efficacy in terms of pain reduction and functional improvement. MTUS page 60 requires recording of pain and function when medications are used for chronic pain. The request is not in accordance with guideline indications. Therefore, the request is not medically necessary.

DME 1/4 Inch Left Heel Lift: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, under Insole/shoe lifts.

Decision rationale: Based on the 09/08/15 progress report provided by treating physician, the patient presents with midline lumbosacral and left hip pain. The request is for DME 1/4 Inch Left Heel Lift. Patient's diagnosis per Request for Authorization form dated 09/09/15 includes degeneration lumbar-lumbosacral intervertebral disc, sprain/strain thoracic and lumbar regions, and enthesopathy hip region. Treatment to date has included imaging studies, injections, activity modifications and medications. Patient's medications include Tramadol, Voltaren gel and Lidoderm patch. The patient is on modified duty working full-time, per 07/31/15 report. ODG Guidelines, Low Back Chapter under Insole/shoe lifts states: "Recommended as an option for patients with a significant leg length discrepancy or who stand for prolonged periods of time. Not recommended for prevention...They may be helpful for patients with a significant leg length discrepancy (> 2-3cm) or with prolonged walking requirements...Given the low cost and low potential for harms, shoe insoles are a treatment option. Shoe lifts may not be appropriate for treatment of acute low back problems when lower limb length difference is ≤ 2 cm. (Basford,

1988)" Treater has not provided medical rationale for the request. Physical examination of the lumbar spine on 09/08/15 revealed tenderness to palpation over the interspinous processes of the lower lumbar spine with mild paracentral tenderness, asymmetric iliac crest height and painful range of motion. ODG supports heel lift for acute low back problems when lower limb length difference is greater than 2cm. In this case, there is no documentation that patient's discrepancy in leg length is greater than 2cm. The request for 1/4 inch heel lift is not in accordance with guideline indications. Therefore, the request is not medically necessary.