

Case Number:	CM15-0020610		
Date Assigned:	02/10/2015	Date of Injury:	01/11/1994
Decision Date:	03/27/2015	UR Denial Date:	01/21/2015
Priority:	Standard	Application Received:	02/04/2015

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, Pain Management

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 male with an industrial injury dated 01/11/1994 while moving an overhead rack resulting in back and leg pain. His diagnoses include low back pain, arthropathy unspecified, post laminectomy syndrome of the lumbar region, myalgia and myositis, chronic pain due to trauma, and thoracic and lumbosacral neuritis or radiculitis. Recent diagnostic testing has included x-rays of the lumbar spine (0/21/2014) without discussion of results. Previous treatments have included back fusion surgery (1994), spinal cord stimulator replacement (2011), conservative care, medications, physical therapy, and psychological therapy. In a progress note dated 01/07/2015, the treating physician reports persistent severe back pain that radiates to the left lower extremity with a pain rating of 10/10 without medications and 7/10 with medications. The objective examination revealed an antalgic gait, tenderness to palpation of the paraspinal facets, spinous gluteal region, piriformis, quadratus and sciatic notch, painful movement in the lumbar region and buttocks, restricted range of motion in the lumbar spine. The treating physician is requesting Lyrica and Flector which were denied/modified by the utilization review. On 01/21/2015, Utilization Review modified a prescription for Lyrica 100mg #480 to the approval of Lyrica 100mg #40, noting the absence of documented neuropathic diagnosis to support the use of this medication, and recommendation for weaning. The ODG Guidelines were cited. On 01/21/2015, Utilization Review non-certified a prescription for Flector 1.3% #90, noting the lack of recommendation for use in the treatment of osteoarthritis of the spine, hip or shoulder. The MTUS Guidelines were cited. On 02/03/2015, the injured worker submitted an application for IMR for review of Lyrica 100mg #480 and Flector 1.3% #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lyrica 100mg #480: 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 Antiepilepsy Drugs Page(s): 16-21.

Decision rationale: Regarding request for Lyrica, Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is some neuropathic pain relief noted, although specific objective functional improvement is not clearly identified. Although some additional use of the medication may be indicated, there is no clear indication for a quantity of #480, as this is not conducive to regular reevaluation for efficacy and continued need. Unfortunately, there is no provision for modification of the request to allow for an appropriate amount of medication. In light of the above issues, the currently requested Lyrica is not medically necessary.

Flector 1.3% QTY 90: 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 Topical Analgesics Page(s): 111-113.

Decision rationale: Regarding the request for Flector, CA MTUS states that topical NSAIDs are indicated for 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. Within the documentation available for review, none of the above mentioned criteria have been documented. Given all of the above, the requested Flector is not medically necessary.