

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0022924 | | |
| Date Assigned: | 02/12/2015 | Date of Injury: | 11/13/1999 |
| Decision Date: | 04/06/2015 | UR Denial Date: | 01/23/2015 |
| Priority: | Standard | Application Received: | 02/06/2015 |

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, Arizona

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 49-year-old female who reported an injury on 11/13/1999. The mechanism of injury was not provided. There was a Request for Authorization submitted for review dated 01/16/2015. The documentation of 01/14/2015 revealed the injured worker's diagnoses included disorders of the sacrum and degeneration of the lumbar or lumbosacral intervertebral disc. The injured worker had complaints of back pain, leg pain, and hip pain. The purpose of the office visit was noted to be a medication refill. Prior treatments included epidural steroid injections and medications. The injured worker's surgical history was noncontributory. The CURES report was within normal limits. The injured worker was noted to undergo urine drug screens and CURES reports. The medications were noted to include hydrocodone 10/325 mg 1 every day as needed for moderate pain (4/10 to 6/10) or severe pain (7/10), morphine ER 15 mg every 12 hours, and Soma 350 mg 1 tablet by mouth as needed at bedtime. The injured worker's gait was slow and guarded. The injured worker had painfulness to light palpation diffusely. The injured worker had decreased range of motion. The injured worker had diffuse lower lumbar muscle spasming. The documentation indicated the injured worker had been utilizing MS Contin 15 mg every 8 hours and Norco #4 daily. The symptoms were progressively getting worse and the regimen was not able to stay on top of the pain. As such, the injured worker was noted to be given MS Contin every 8 hours. The injured worker indicated that her function was greater when she was allowed to have it every 8 hours. The injured worker was unable to perform activities of daily living when she did not take the MS Contin and the Norco

as recommended. The injured worker indicated she had been utilizing a TENS unit daily for several years, as were the previously mentioned medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Morphine ER 15 mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management, opioid dosing Page(s): 60,78,86.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opioids for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation indicated the injured worker was being monitored for aberrant drug behavior and had objective functional benefit with the use of the medication. There was a lack of documentation of an objective decrease in pain with use of the medications. There was a lack of documented side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for morphine ER 15 mg #90 is not medically necessary.

Lidoderm patches 5% #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56, 57.

Decision rationale: The California Medical Treatment & Utilization Schedule Guidelines indicate that topical lidocaine (Lidoderm) 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). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide documented efficacy for the requested medication. The request as submitted failed to indicate the frequency and the body part to be treated with the Lidoderm patches. Given the above, the request for Lidoderm patches 5% #60 is not medically necessary.

