

Case Number:	CM15-0024372		
Date Assigned:	03/19/2015	Date of Injury:	06/07/2009
Decision Date:	04/13/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/09/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 46 year old female who sustained an industrial injury on 06/07/2009. Current diagnoses include lumbago, intervertebral disc disease with myelopathy, and displacement of intervertebral disc. Previous treatments included medication management, physical therapy, ice therapy, TENS unit, steroid injection, chiropractic treatments, and individual psychological sessions. Current diagnostic studies included MRI. Initial complaints included burning in her back and sharp shooting pains down her legs. The documentation submitted did not contain any current or recent reports for review. The most recent report dated 09/04/2014/2014 noted that the injured worker presented with complaints that included low back pain. Medication regimen for 09/04/2004 included Norco, Nortriptyline, Lidoderm patch, Flexeril, and Pepcid. Pain level was rated as 7-8 out of 10 on the visual analog scale (VAS). Physical examination was positive for abnormal findings. The treatment plan included using the TENS unit, Norco, Nortriptyline, and Lidoderm patch. The physician noted that the Lidoderm patch helps with significant amounts of pain in her back and feet, and the use of the Lidoderm patch helps her to take less narcotics.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro (DOS 1/15/15): Alprazolam 0.25mg #30 with 0 refills: 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); (Xanax) (updated 1/19/15).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines- Page(s): 24.

Decision rationale: Retro (DOS 1/15/15): Alprazolam 0.25mg #30 with 0 refills is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. The documentation indicates that the patient has been on Alprazolam dating back to at least September of 2014. The documentation does not indicate extenuating circumstances, which would necessitate going against guideline recommendations. The request for retro Alprazolam is not medically necessary

Retro (DOS 1/15/15): Lidocaine Pads 5% #30 with 0 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111, 112, 56 and 57.

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

Decision rationale: Retro (DOS 1/15/15): Lidocaine Pads 5% #30 with 0 refills is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines The guidelines state that 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). 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. The documentation does not indicate evidence of significant functional improvement or pain relief related to prior Lidocaine use. The documentation does not indicate a diagnosis of post herpetic neuralgia. For these reasons the request for retro (DOS 1/15/15): Lidocaine Pads 5% #30 with 0 refills is not medically necessary.