

Case Number:	CM15-0027359		
Date Assigned:	02/19/2015	Date of Injury:	07/18/2013
Decision Date:	04/07/2015	UR Denial Date:	01/16/2015
Priority:	Standard	Application Received:	02/13/2015

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 53 year old male, who sustained a work/ industrial injury on 7/18/13 as a project supervisor. He has reported symptoms of increasing pain in the left groin and back radiating into the hip. Pain was 7/10. Medical history includes asthma, gastroesophageal reflux disease (GERD), left hip arthroscopy on 5/15/14 and sciatica. The diagnoses have included lumbar sprain with radiculopathy and left hip post surgery. Treatments to date included medication trigger point injections, physical therapy, and conservative care. Medications included Bupropion HCL, Omeprazole, Clonazepam, Combivent, Pristiq, Gabapentin, Colace, and OxyContin. Exam noted ambulation with a guarded gait, grossly positive straight leg raising, discomfort about the left lumbar spine with aching and shooting sharp pain down into the left groin, internal and external rotation also increase pain and pain with weight bearing. A request was made for OxyContin, Voltaren gel, and Lidoderm patch for persistent pain to the back, left groin and hip areas. On 1/16/15, Utilization Review non-certified a Prospective use of Oxycodone 10mg #30; Prospective use of Voltaren gel with 1 refill Prospective use of Lidoderm patches #30 with 1 refill, noting the California Medical treatment Utilization Schedule (MTUS) Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective use of Oxycodone 10mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: This patient presents with left low back, sacroiliac, and left hip region pain. The current request is for prospective use of oxycodone 10 mg #30. For chronic opiate use, the MTUS Guidelines page 88 and 89 states, "Pain should be assessed at each visit and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4 As including analgesia, ADLs, adverse side effects and adverse behavior. Pain assessment or outcome measures should also be provided to include current pain, average pain, least pain, intensity of pain with medication, time it takes for medication to work, and duration of pain relief. Review of the medical file indicates the patient has been utilizing oxycodone since 10/28/2014. According to progress report dated 11/17/2014 noted a "pain contract and urine drug screen will be done in accordance with protocol." The patient reported that medications give him good analgesia. The treating physician states there is no evidence of abuse, diversion, adverse reaction, and the patient manages his constipation. According to progress report dated 01/08/2015, a refill for oxycodone was made for patient's persistent pain and the treating physician stated that the patient controls side effects and constipation with diet, lifestyle, and stool softeners as needed. In this case, there is no specific discussion regarding medication efficacy. Recommendation for further use cannot be supported as the treating physician has not provided any specific functional improvement, changes in ADLs or change in work status to document significant functional improvement. There are no before and after pain scale to denote decrease in pain. Furthermore, treating physician states that urine drug screen would be obtained in accordance with guidelines. However, there are no urine drug screen reports provided for review and there are no discussions regarding possible aberrant behaviors. The treating physician has failed to provide the minimum requirements as required by MTUS for opiate management. The requested oxycodone is not medically necessary.

Prospective use of Voltaren gel with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesic Page(s): 111-113.

Decision rationale: This patient presents with left low back, sacroiliac, and left hip region pain. This is a request for prospective use of Voltaren gel with 1 refill. For topical agents, the MTUS Guidelines page 111 states, "Topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." MTUS further states "Neuropathic pain: Not recommended as there is no evidence to support. FDA approved agent: Voltaren gel 1% (diclofenac): Indicated for relief of osteoarthritis pain and joints that lend themselves to

topical treatment ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for the treatment of the spine, hip, or shoulder." In this case, the patient presents with left low back, sacroiliac, and left hip region pain. This patient does not meet the indication for this medication as he does not present with osteoarthritis and tendinitis. Topical NSAID is recommended for acute and chronic pain conditions, particularly arthritis affecting the peripheral joints. The requested Voltaren gel is not medically necessary.

Prospective use of Lidoderm patches #30 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical lidocaine Page(s): 56-57, 111-113. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Lidoderm.

Decision rationale: This patient presents with left low back, sacroiliac, and left hip region pain. This is a request for prospective use of Lidoderm patch #30 with 1 refill. The MTUS Guidelines page 57 states, "Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of trial of first line therapy tricyclic or SNRI, antidepressants, or AED such as gabapentin or Lyrica." The MTUS page 112 also states, "Recommended for localized peripheral pain." When reading ODG Guidelines, it specifies that Lidoderm patches are indicated as a trial if there is "evidence of localized pain and that it is consistent with neuropathic etiology." ODG further request documentation at the area for treatment, trial of short-term use with outcome documenting the pain and function. This is an initial request for Lidoderm patches. In this case, the treating physician does not document peripheral pain that is neuropathic and localized, as required by MTUS for the use of lidocaine patches. This request is not medically necessary.