

Case Number:	CM15-0223097		
Date Assigned:	11/19/2015	Date of Injury:	10/04/2010
Decision Date:	12/30/2015	UR Denial Date:	10/13/2015
Priority:	Standard	Application Received:	11/12/2015

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: Preventive Medicine, Occupational 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 56 year old female, who sustained an industrial injury on 10-4-2010. The injured worker is undergoing treatment for mood disorder, pain in unspecified elbow, pain in unspecified hip, cervicobrachial syndrome and other lumbar intervertebral disc degeneration. Medical records dated 10-1-2015 indicate the injured worker complains of increasing neck and back pain rated 3 out of 10 with medication and 5 out of 10 with medication and poor sleep. Physical exam dated 10-1-2015 notes lumbar tenderness to palpation and tenderness to palpation over the trochanter. Treatment to date has included epidural steroid injection, Lidoderm patch, Gabapentin, ibuprofen, Clonidine, Oxybutynin, Cetirizine, Celexa, Lipitor, Omeprazole, Norco, lumbar laminectomy, physical therapy, Transcutaneous Electrical Nerve Stimulation (TENS) unit, acupuncture, aqua therapy and labs. The original utilization review dated 10-13-2015 indicates the request for Lidoderm 5% patch (700mg/patch) #30 and Gabapentin 300mg #120 with 1 refill is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm 5% patch (700mg/patch) #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Lidoderm is a Lidocaine patch providing topical Lidocaine. The MTUS Guidelines recommend the use of topical Lidocaine primarily for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no clear evidence in the clinical reports that this injured worker has neuropathic pain that has failed treatment with trials of antidepressants and anticonvulsants. This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. The request for Lidoderm 5% patch (700mg/patch) #30 is determined to not be medically necessary.

Gabapentin 300mg #120 with 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: The MTUS Guidelines recommend the use of anti-epilepsy drugs for neuropathic pain. Most randomized controlled trials for the use of anti-epilepsy drugs for neuropathic pain have been directed at post-herpetic neuralgia and painful polyneuropathy, with polyneuropathy being the most common example. There are few RCTs directed at central pain, and none for painful radiculopathy. A good response to the use of anti-epilepsy drugs has been defined as a 50% reduction in pain and a moderate response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response to this magnitude may be the trigger for switching to a different first line agent, or combination therapy if treatment with a single drug fails. 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 anti-epilepsy drugs depends on improved outcomes versus tolerability of adverse effects. Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first line treatment for neuropathic pain. The clinical documentation does not clearly show that the injured worker has neuropathic symptoms. The injured worker is reported to having improved pain and in activities of daily living, but there are no clinical findings that confirm functional improvement. The request for Gabapentin 300mg #120 with 1 refill is determined to be not medically necessary.