

Case Number:	CM15-0032653		
Date Assigned:	02/26/2015	Date of Injury:	03/03/2012
Decision Date:	04/09/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/20/2015

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, Hawaii
 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 sustained an industrial injury on 03/03/2012. The diagnoses have included displacement intervertebral disc without myelopathy. Noted treatments to date have included lumbar spine surgery, injections, and medications. No MRI report noted in received medical records. In a progress note dated 12/08/2014, the injured worker presented with complaints of left lower extremity weakness, left groin symptoms, and increased symptoms status post-lumbosacral fusion. The treating physician reported lumbosacral tenderness with spasm. Utilization Review determination on 01/23/2015 non-certified the request for Tylenol #3 #60 and Lidoderm Patches #30 citing Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tylenol #3 #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Codeine,Opioids Page(s): 35, 74-94.

Decision rationale: The patient presents with displacement intervertebral disc without myelopathy. Current complaints are of left lower extremity weakness, left groin symptoms, and increased symptoms status post-lumbosacral fusion. The current request is for Tylenol #3 (acetaminophen and codeine) #60. Codeine is an opioid pain medication. Acetaminophen is a less potent pain reliever that increases the effects of codeine. Acetaminophen and codeine is a combination medicine used to relieve moderate to severe pain. The treating physician requests on 1/12/15 (B65), "Tylenol #3 bid prn pain (#60)". MTUS guidelines support the usage of Tylenol with Codeine for the treatment of chronic pain. MTUS Guidelines pages 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 4A's (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, recommendation for further use of Tylenol #3 cannot be supported as the treating physician does not provide before and after scales to show analgesia; no specific ADLs are discussed and no change of work status or return to work to show significant functional improvement is documented. There is no discussion of adverse side effects and aberrant behaviors are not addressed. Urine toxicology reports are not provided as well. Given the lack of sufficient documentation for opiate management, recommendation is for denial.

Lidoderm Patches #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56, 112.

Decision rationale: The patient presents with displacement intervertebral disc without myelopathy. Current complaints are of left lower extremity weakness, left groin symptoms, and increased symptoms status post-lumbosacral fusion. The current request is for Lidoderm Patches #30. The treating physician requests on 1/12/15 (B65), "Lidoderm patches #30 (apply 1 patch 12 hrs on 12 hrs off)." MTUS guidelines state, "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)." MTUS also states, "Recommended for localized peripheral pain." When reading ODG guidelines, it specifies that Lidoderm patches be indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function." Review of the reports show that the patient has been using this medication since 8/8/14. In this case, there is no documentation of the area of treatment, positive response or improvement with utilizing Lidoderm patches. Additionally, the clinical reports provided do not document peripheral,

localized neuropathic pain for which Lidoderm patches are indicated. The current request is not medically necessary and the recommendation is for denial.