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| Case Number: | CM15-0055771 | | |
| Date Assigned: | 04/01/2015 | Date of Injury: | 05/24/2012 |
| Decision Date: | 05/01/2015 | UR Denial Date: | 02/25/2015 |
| Priority: | Standard | Application Received: | 03/24/2015 |

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 (IW) is a 45 year old female who sustained an industrial injury on 05/24/2012. She reported pain in the right shoulder, low back, and wrist. The injured worker was diagnosed as having low back pain, degenerative disc disease, lumbar facet joint arthritis, bilateral sacroiliitis, right wrist pain, right shoulder pain, and possibility of lumbar radiculopathy. Treatment to date has included diagnostic MRI, and electrodiagnostic studies of the right upper extremity. Currently, the injured worker complains of persistent low back, and right wrist and hand pain aggravated by activity. Current medications are helping for pain and she is requesting refills of her medications. The treatment plan is to await a pending MRI of the thoracic spine for medical decision making, and request refills of her medications. Requests for authorization were submitted for Norco 5/325mg QTY: 240.00, Lidoderm patch 5% QTY: 240.00 and Voltaren gel 1% QTY: 4.00.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patch 5% QTY: 240.00: Upheld

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

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

Decision rationale: MTUS Guidelines recommend topical lidoderm under specific circumstances, which include a diagnosis of a localized peripheral neuropathic pain syndrome plus prior failure of oral medications for neuropathic pain. Neither of these conditions appears to be met. The Lidoderm is recommended for the low back pain and no oral meds for neuropathic pain have been trialed. There are no unusual circumstances (improved function or diminished use of other meds) to justify an exception to Guidelines. Under these circumstances, the Lidoerm patch 5% #240 is not supported by Guidelines and is not medically necessary.

Voltaren gel 1% QTY: 4.00: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56, 111-113.

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

Decision rationale: MTUS Guidelines support at least a trial of topical NSAIDs for superficial joints or tendonitis. The recommended use of Voltaren is not well documented, but some of this individual's conditions would be consistent with a Guideline recommended trial. If there are no benefits during a several week trial, this can be re-reviewed for the appropriateness of continued use. The Voltaren gel 1% Qty 4 is medically necessary.