

Case Number:	CM15-0058981		
Date Assigned:	04/03/2015	Date of Injury:	10/24/2002
Decision Date:	05/26/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/27/2015

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, Montana
 Certification(s)/Specialty: Internal Medicine, Infectious Disease

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 48-year-old female who reported injury on 10/24/2002. The mechanism of injury was the injured worker fell out of a chair. The injured worker was noted to undergo a C5-6 anterior fusion in 04/2005. The injured worker underwent an MRI of the cervical spine on 03/13/2012. The injured worker was noted to undergo urine drug screens. The injured worker was noted to have a urine drug screen on file. The documentation of 03/11/2015 revealed the injured worker's physical activity, sleep, and social life continued to be adversely affected due to the severity of pain. The injured worker indicated she had 60% analgesic effect due to the medications. Prior treatments included epidural steroid injections. The injured worker complained of neck and low back pain with radiation of pain down the bilateral upper extremities and bilateral lower extremities. The medications included Neurontin 300 mg 1 capsule 4 times a day; Tylenol No. 4 one capsule 3 times a day, and Lidoderm patches 5% patch, 1 to 3 patches every 24 hours. The examination revealed decreased range of motion of the cervical spine. The diagnoses included cervical radiculitis and postlaminectomy syndrome of the cervical spine, degenerative disc disease of the cervical spine. trochanteric bursitis, long term use medications NEC, sacroiliitis, and postlaminectomy syndrome of the lumbar spine. The treatment plan included a C6-7 translaminar cervical epidural steroid injection, followed by physical therapy; and a continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Epidural Steroid Injection with Oral Sedation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision rationale: The California MTUS Guidelines recommend repeat epidural steroid injections for injured workers who have documented greater than 50% pain relief for 6 to 8 weeks, and there should be documentation of objective functional improvement, and an objective decrease in pain medications for the same amount of time. The referenced guidelines, however, do not address sedation. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that a major concern is that sedation may result in the inability of the injured worker to experience the expected pain and paresthesias associated with spinal cord irritation. Routine use is not recommended, except for injured workers with anxiety. The clinical documentation submitted for review failed to provide a rationale for the requested oral sedation. The injured worker was noted to undergo prior epidural steroid injections. The levels and whether they were in the cervical spine or lumbar spine were not provided. There was a lack of documentation of greater than 50% pain relief and documentation of objective functional improvement and an objective decrease in pain medications for 6 to 8 weeks. Additionally, the request as submitted failed to indicate the level and laterality for the requested intervention. Given the above, the request for cervical epidural steroid injection with oral sedation is not medically necessary.

Neurontin 300mg #120 date of service: 2/13/15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

Decision rationale: The California MTUS guidelines recommend antiepilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30% - 50% and objective functional improvement. The clinical documentation submitted for review dated 02/13/2015 revealed the injured worker had 60% analgesic effect with medications and showed no diversionary or aberrant behavior. However, there was a lack of documentation of objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Neurontin 300 mg #120, date of service: 2/13/15, is not medically necessary.

Tylenol #4 #90 date of service: 2/13/15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60,78.

Decision rationale: The clinical documentation submitted for review indicated the injured worker was being monitored for aberrant drug behavior and side effects. The injured worker has objective pain relief. However, there was a lack of documentation of objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Tylenol #4 #90 date of service: 2/13/15 is not medically necessary.

Lidoderm patches #90; date of service: 2/13/15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56, 57.

Decision rationale: The California Medical Treatment & Utilization Schedule guidelines indicate that topical lidocaine (Lidoderm) 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. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide the injured worker had a trial and failure of first line therapy. There was a lack of documentation of objective functional benefit that was received from the medication. The request as submitted failed to indicate the frequency for the requested medication. Given the above and the lack of documentation, the request for Lidoderm patches #90; date of service: 2/13/15 is not medically necessary.