

Case Number:	CM15-0059200		
Date Assigned:	04/03/2015	Date of Injury:	09/04/2009
Decision Date:	06/01/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	03/29/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 65-year-old male who reported injury on 09/04/2009. The mechanism of injury was not provided. The documentation of 02/18/2015 revealed the injured worker's diagnoses included displacement of lumbar intervertebral disc without myelopathy and degeneration of lumbar intervertebral disc, as well as lumbar postlaminectomy syndrome. The injured worker had complaints of chronic bilateral low back pain. The injured worker was performing stretches and exercises at home. The injured worker was utilizing Suboxone 2 mg one 3 to 4 times a day. The injured worker had an adverse side effect of constipation. The medication provided a 50% decrease in pain. The injured worker was utilizing Lidoderm patches and Voltaren gel. The injured worker was utilizing Miralax. The treatment plan included a refill of the medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Suboxone 2mg -0.5mg sublingual film, quantity 120 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 26-27.

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

Decision rationale: The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker had a 50% decrease in pain and had adverse side effects. However, there was a lack of documentation indicating the injured worker was being monitored for aberrant drug behavior, and the injured worker had objective functional improvement with the use of the medication. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documented rationale for 2 refills without re-evaluation. Given the above, the request for Suboxone 2 mg, 0.5 mg sublingual film, quantity 120 with 2 refills is not medically necessary.

Voltaren 1% topical gel, quantity 200gm with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111, 56-57, 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 12.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that Voltaren Gel 1% (Diclofenac) is an FDA-approved agent indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The clinical documentation submitted for review failed to indicate the injured worker had osteoarthritis. The request as submitted failed to indicate the frequency and the body part to be treated. There was a lack of documented rationale for 5 refills without re-evaluation. There was no functional benefit noted. Given the above, the request for Voltaren 1% topical gel, quantity 200 gm with 5 refills is not medically necessary.

Miralax 17gm/dose oral powder, quantity 510gm jar with five refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Baldeno YC1, Lugo E. -Abstract.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Initiation of Opioid Therapy Page(s): 77.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend that when initiating opioid therapy, prophylactic treatment of constipation should be initiated. The clinical documentation submitted for review indicated the injured worker had constipation due to opioid use. However, there was a lack of documented efficacy for the requested medication. There was a lack of documented rationale for 5 refills without re-

evaluation. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Miralax 17 gm/dose oral powder, quantity 510 gm jar with five refills is not medically necessary.

Lidocaine 5% 700mg/patch quantity 30 with two refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111; 56-57; 112.

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 that the injured worker had a trial and failure of first line therapy. There was a lack of documentation indicating objective functional benefit that was received. The request as submitted failed to indicate the frequency for the requested topical patch. There was a lack of documented rationale for 2 refills without re-evaluation. Given the above, the request for Lidocaine 5% 700 mg/patch quantity 30 with two refills is not medically necessary.