

Case Number:	CM15-0059254		
Date Assigned:	04/03/2015	Date of Injury:	11/15/1994
Decision Date:	05/07/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	03/30/2015

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: Montana

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 52 year old male who sustained an industrial injury to on November 15, 1994. The injured worker was diagnosed with lumbar spondylosis without myelopathy. Recent treatment to date included diagnostic testing, physical therapy, chiropractic therapy, epidural steroid injection (ESI), medial branch blocks and medications. According to the primary treating physician's progress report on March 12, 2015, the injured worker presents for low back pain radiating to the bilateral lower extremities. Examination of the lumbar spine demonstrated tenderness to palpation over the lumbar paraspinal muscles and lumbar facet joints with decreased range of motion with pain. Sensation and motor strength were symmetrical and intact bilaterally. Ankle deep tendon reflexes were decreased bilaterally. Current medications are listed as Norco, Pantoprazole, Nabumetone, Orphenadrine, and Lidoderm patches. Treatment plan discussed the injured worker as a candidate for a medial branch rhizotomy and the current request for Nabumetone and Lidoderm patches.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm Patches 700 mg Qty 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lidoderm patches.

Decision rationale: The MTUS states that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Their use is largely experimental with few randomized controlled trials to determine efficacy or safety. Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. The ODG guidelines also state that Lidoderm patches are not a first-line treatment and are FDA approved only for postherpetic neuralgia. ODG Criteria for use of Lidoderm patches include: (a) Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. (b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). (c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. (d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale. (e) The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day). (f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks). (g) It is generally recommended that no other medication changes be made during the trial period. (h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued. In this case there is no documentation of failure of antidepressant or anticonvulsant treatment. The Request for Authorization for Lidoderm patches does not include the area for treatment. There is no diagnosis of neuropathic pain. The guidelines note that it is not generally recommended for treatment of osteoarthritis. The request for Lidoderm patches 5%, 700mg #30 is not medically necessary.

Nabumetone 500 mg Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs Page(s): 67-73.

Decision rationale: The MTUS states that for chronic low back pain non-steroidal anti-inflammatory drugs (NSAIDs) are recommended as an option for short-term symptomatic relief.

A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. (Roelofs-Cochrane, 2008) See also Anti-inflammatory medications. There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis with neuropathic pain. Besides the above well-documented side effects of NSAIDs, there are other less well known effects of NSAIDs, and the use of NSAIDs has been shown to possibly delay and hamper healing in all the soft tissues, including muscles, ligaments, tendons, and cartilage. (Maroon, 2006) For osteoarthritis (including knee and hip) NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Nabumetone (Relafen, generic available): 500, 750 mg. DNon-steroidal anti-inflammatory drugs dosing: Osteoarthritis: The recommended starting dose is 1000 mg PO. The dose can be divided into 500 mg PO twice a day. Additional relief may be obtained with a dose of 1500 mg to 2000 mg per day. The maximum dose is 2000 mg/day. Patients weighing less than 50 kg may be less likely to require doses greater than 1000 mg/day. The lowest effective dose of nabumetone should be sought for each patient. Use for moderate pain is off-label. (Relafen Package Insert) In this case NSAIDs have been used for over 2 years with the most recent medical record documenting increased pain levels. The guidelines state that there is no evidence of long-term effectiveness for pain or function. The request for Nabumetone 500 mg Qty 60 is not consistent with the MTUS guidelines and is not medically necessary.