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| Case Number: | CM15-0059521 | | |
| Date Assigned: | 04/06/2015 | Date of Injury: | 10/16/1995 |
| Decision Date: | 05/05/2015 | UR Denial Date: | 03/10/2015 |
| 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: New York, Pennsylvania, Washington
 Certification(s)/Specialty: Internal Medicine, Geriatric 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 73 year old female with an industrial injury dated October 16, 1995. The injured worker diagnoses include low back pain, degeneration of cervical intervertebral disc, carpal tunnel syndrome, degeneration of lumbar intervertebral disc, lumbosacral radiculitis, and disorder of trunk. She has been treated with diagnostic studies, home exercise therapy, prescribed medications and periodic follow up visits. According to the progress note dated 02/23/2015, the injured worker presented for follow up for low back pain with radiculopathy. The treating physician noted that her pain is well controlled with her prescribed medications. The treating physician prescribed Hydrocodone 7.5-Acetaminophen 325mg (do not fill until 04/20/15), Hydrocodone 7.5-Acetaminophen 325mg (do not fill until 3/23/15) and Lidoderm Patch 5 % now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 7.5-Acetaminophen 325mg (do not fill until 3/23/15) Qty 160: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26.

Decision rationale: This injured worker has chronic pain with an injury sustained in 1995. The medical course has included numerous treatment modalities including use of several medications such as narcotics. Per the guidelines, in opioid use, ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects is required. Satisfactory response to treatment may be reflected in decreased pain, increased level of function or improved quality of life. The MD visits fail to document any significant improvement in pain, functional status or a discussion of side effects specifically related to opioids to justify use per the guidelines. Additionally, the long-term efficacy of opioids for chronic back pain is unclear but appears limited. The medical necessity of Hydrocodone 7.5-Acetaminophen 325mg is not substantiated in the records. The request is not medically necessary.

Hydrocodone 7.5-Acetaminophen 325mg (do not fill until 04/20/15) Qty 160: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 74-80.

Decision rationale: This injured worker has chronic pain with an injury sustained in 1995. The medical course has included numerous treatment modalities including use of several medications such as narcotics. Per the guidelines, in opioid use, ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects is required. Satisfactory response to treatment may be reflected in decreased pain, increased level of function or improved quality of life. The MD visits fail to document any significant improvement in pain, functional status or a discussion of side effects specifically related to opioids to justify use per the guidelines. Additionally, the long-term efficacy of opioids for chronic back pain is unclear but appears limited. The medical necessity of Hydrocodone 7.5-Acetaminophen 325mg is not substantiated in the records. Therefore, the request is not medically necessary.

Lidoderm Patch 5 % Qty 90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 56-57 and 112.

Decision rationale: This injured worker has chronic pain with an injury sustained in 1995. Per the guidelines, 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). 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. Lidoderm is FDA approved only for post-herpetic neuralgia and the worker is concurrently receiving first line therapy for neuropathic pain. The medical records do not support medical necessity for the prescription of Lidoderm in this injured worker. Therefore, the request is not medically necessary.