

Case Number:	CM14-0095991		
Date Assigned:	07/25/2014	Date of Injury:	08/18/2003
Decision Date:	10/07/2014	UR Denial Date:	05/21/2014
Priority:	Standard	Application Received:	06/24/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 female who had a work related injury on 08/18/13. The mechanism of injury is not described. The most recent medical record submitted for review is dated 05/01/14. The injured worker was in the office today for mid-back pain and lower back ache. Pain level has remained unchanged since last visit. No new problems or side effects. Quality of sleep is poor. She denies any new injury since her last visit. Her activity level has decreased. The injured worker is taking her medication as prescribed. She states that medications are working well. No side effects reported. No medication abuse is suspected. Overall she is doing okay. She notes significant benefit from the Lidoderm patch. Current medications Cymbalta 60mg tablets, Ibuprofen 600mg tablets, Zanaflex 4mg tablets, Norco 10/325mg, Lidoderm 5% patch, Abilify 5mg tablets. Physical examination she appears to be well-groomed. Appears to be well-nourished and well-developed. She has good communication ability. She does not show signs of intoxication or withdrawal. The injured worker has global antalgic gait. Does not use assistive devices. Lumbar spine no scoliosis, asymmetry, or abnormal curvature noted on inspection of the lumbar spine. Range of motion is restricted with extension limited to 15 degrees, limited by pain but normal flexion. On palpation, paravertebral muscles, spasm, and tenderness is noted on both the sides. Lumbar facet loading is positive on both sides. Straight leg raising test is positive on both sides in sitting at 10 degrees. Babinski's sign is negative. The injured worker moves all extremities well. Diagnosis lumbar facet syndrome. Depression. Spine thoracic degenerative disc disease. Prior utilization dated 05/21/14 was non-certified. In reviewing the medical records submitted, there are no VAS scores with and without medication as well as no documentation of functional improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm Patches 5% #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain

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

Decision rationale: As noted on page 56 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Lidoderm is recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. 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). Lidoderm is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. Therefore this compound cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

Ibuprofen 600mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 70.

Decision rationale: As noted on page 70 of the Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended as a second-line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute lower back pain. Package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). There is no documentation that these monitoring recommendations have been performed and the patient is being monitored on a routine basis. Additionally, it is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. As such, the request for this medication cannot be established as medically necessary.

Zanaflex 4mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

Decision rationale: As noted on page 63 of the Chronic Pain Medical Treatment Guidelines, muscle relaxants are recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the patient has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. As such, the medical necessity of this medication cannot be established at this time.

Norco 10/325mg #168: Upheld

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

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

Decision rationale: Current evidenced-based guidelines indicate patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is insufficient documentation regarding the functional benefits and functional improvement obtained with the continued use of narcotic medications. Documentation does not indicate a significant decrease in pain scores with the use of medications. Therefore medical necessity has not been established. However, these medications cannot be abruptly discontinued due to withdrawal symptoms, and medications should only be changed by the prescribing physician.