MAXIMUS Federal Services

Case Number:	CM14-0213262		
Date Assigned:	12/30/2014	Date of Injury:	11/03/1973
Decision Date:	02/24/2015	UR Denial Date:	12/02/2014
Priority:	Standard	Application Received:	12/19/2014

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. 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: Tennessee, Mississippi
Certification(s)/Specialty: Anesthesiology, 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:

This is an 87-year-old male with an 11/3/73 date of injury. According to a progress report dated 11/4/14, the patient complained of continuous, tight, stabbing, throbbing, cramping, and shooting pain, rated as a 7/10, located in the back. The pain was aggravated by not taking medications and was relieved with spinal stimulator. He estimated that approximately 40 percent of his pain was eliminated by the medication he was taking for pain and by non-opioid pharmacological strategies. He stated that his opioid medication improved his function significantly and substantially reduced pain. A urine drug screen dated 11/4/14 was appropriately positive for oxycodone and appropriately negative for all other tested substances. Objective findings: musculoskeletal exam not performed at this visit, alert and oriented, speech was not slurred. Diagnostic impression: failed back syndrome, lumbar radiculopathy, thoracic spondylosis, Alzheimer's disease, bilateral shoulder pain, obstructive sleep apnea. Treatment to date: medication management, activity modification, epidural steroid injections, spinal cord stimulator. A UR decision dated 12/2/14 denied the request for Lidoderm patch and modified the request for Percocet from 160 tablets to 60 tablets. Regarding Lidoderm, though the current medication regimen is subjectively reported to decrease pain, there is no documentation of objective functional benefit with prior use of this medication. Regarding Percocet, the reports provided do not indicate failed trials of first-line recommendations (oral antidepressants and anticonvulsants). Though the current medication regimen is subjectively reported to decrease pain, there is no documentation of objective functional benefit with prior use of this medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patch 5% #3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Lidoderm Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter - Lidoderm.

Decision rationale: California MTUS states that 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). Official Disability Guidelines (ODG) states that Lidoderm is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. However, in the present case, there is no discussion in the reports regarding the patient failing treatment with a first-line agent such as gabapentin. In addition, there is no documentation that the patient is unable to take oral medications. Therefore, the request for Lidoderm patch 5% #3 was not medically necessary.

Percocet 10/325mg #160: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Opiates Page(s): 78-81.

Decision rationale: California MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, given the 1973 date of injury, nearly four decades ago, the duration of opiate use to date is not clear. There is no discussion regarding non-opiate means of pain control, or endpoints of treatment. Therefore, the request for Percocet 10/325mg #160 was not medically necessary.