

Case Number:	CM14-0216678		
Date Assigned:	01/06/2015	Date of Injury:	10/06/2008
Decision Date:	02/28/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	12/26/2014

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: New Jersey, New York
 Certification(s)/Specialty: Family Practice

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 49 year-old female who was injured on 10/6/08. She complained of lower back and left leg pain. On exam, she had an antalgic gait, with decreased range of motion of lumbar spine, trigger points in left lower lumbar paraspinal, tender left sacroiliac joint, normal motor and reflexes of lower extremities. The patient was diagnosed with chronic pain syndrome, trochanteric bursitis, left sacroiliac lumbar radiculopathy, myofascial pain syndrome, low back pain, sprains and strains of sacroiliac ligament, and adjustment disorder with mixed anxiety and depressed mood. The patient is using Gralise to help her sleep and it helped relief 75% of burning sensation in her left leg. She was using Diclofenac and decreased Lidoderm to two patches three times a week. She had a home exercise program. She had transforaminal epidural steroid injection and left greater trochanteric bursa injection. The current request is for voltaren gel, gralise ER, Lidoderm patch which was denied by utilization review on 12/12/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren 1% gel #100 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

Decision rationale: The request is not medically necessary. The use of topical analgesics is largely experimental in use with few randomized controlled trials to determine efficacy or safety. The efficacy of topical NSAIDs have shown inconsistent results in studies. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis and tendinitis, but either not afterward, or with a diminishing effect over another 2-week period. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. The patient has had lower back and leg pain and was using Voltaren longer than two weeks. It is recommended only for short-term use. Topical NSAIDs are not superior to oral NSAIDs and there was no documentation that the patient could not tolerate oral NSAIDs. Therefore, the request is considered not medically necessary.

Gralise ER 600 mg #90 with one refill: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Page(s): 18-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anticonvulsants, Gabapentin Page(s): 16-19, 49.

Decision rationale: The request for Gralise is medically necessary. According to MTUS guidelines, it is effective for neuropathic pain, including diabetic painful neuropathy and postherpetic neuralgia. There should be documentation of pain relief, improvement in function, and side effects experienced by the patient. Medical records indicate that Gralise improved burning pain in her left leg by 75% with increase in ability to do laundry and dishes, and contribute to her household. She was able to decrease her diclofenac. Therefore, the request is considered medically necessary.

Lidoderm 5% patch (700 mg/patch) #60 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm, topical analgesics Page(s): 56-57, 111-112.

Decision rationale: The request is not medically necessary. According to MTUS guidelines, Lidoderm is not first line treatment and is only FDA approved for post-herpetic neuralgia. More research is needed to recommend it for chronic neuropathic pain other than post-herpetic neuralgia. Therefore, the request is considered medically unnecessary.