

Case Number:	CM14-0218956		
Date Assigned:	01/09/2015	Date of Injury:	09/01/2006
Decision Date:	03/06/2015	UR Denial Date:	12/02/2014
Priority:	Standard	Application Received:	12/30/2014

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: California

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 45 year old male, who sustained an industrial injury on 9/1/06. He has reported low back pain. The diagnoses have included lumbago with bilateral radicular symptoms, worse on the right, lumbar disc disease, multilevel and lumbar foraminal stenosis. Treatment to date has included L4-5 transforaminal posterior fusion and L4-L5 laminectomy 10/14. Currently, the IW complains of low back pain intermittent and improving with radiation into bilateral legs. Per the PR2 dated 11/13/14, he has limited range of motion of lumbar spine, healed incision and both lower extremities are intact neurologically. A Request for Authorization was submitted on 11/13/14 for Percocet 10/325 #90 and Diclofenac 3%/Lidocaine 5%. On 12/2/14 Utilization Review non-certified a prescription for Diclofenac/Lidocaine Cream 3%/5% 180 gms, noting the cream has been effective in reducing the severity of low back pain symptoms and reducing the need for stronger narcotic medication, however without evidence of objective functional benefit supporting the subjective improvement, medical necessity cannot be established. The MTUS, ACOEM Guidelines, was cited. Utilization Review also non-certified Percocet 10/325mg #90 noting the recommendations of opioid use for chronic pain, the IW is taking 4 Percocet per day and reports improvement in pain, however there is no evidence of objective functional benefit supporting the subjective improvement. The MTUS, ACOEM Guidelines, was cited. On 12/30/14, the injured worker submitted an application for IMR for review of Diciofencic/Lidocaine cream 3%/5% 180 gm, and Percocet 10/325 mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac/Lidocaine Cream 3 Percent/ 5 Percent 180 Gram: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics section Page(s): 111-113.

Decision rationale: Per the MTUS Guidelines, the use of topical analgesics is recommended as an option for some agents. The MTUS Guidelines recommend the use of topical analgesics as an option for the treatment of chronic pain, however, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Topical lidocaine is used primarily for neuropathic pain when trials of antidepressant and anticonvulsants have failed. 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 (whether creams, lotions or gels) are indicated for neuropathic pain. Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritics. The requested compounded topical analgesic is not recommended because topical lidocaine in the formulation of a cream is not recommended by the MTUS Guidelines. The request for Diclofenac/Lidocaine Cream 3 Percent/ 5 Percent 180 Gram is determined to not be medically necessary.

Percocet 10/325 MG #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section Weaning of medications section Page(s): 74-95, 124.

Decision rationale: The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The medical reports do not indicate that the injured worker has significant functional improvement as a result of use of Percocet. Medical necessity of this request has therefore not been established within the recommendations of the MTUS Guidelines. It is not recommended to

discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The request for Percocet 10/325 MG #90 is determined to not be medically necessary.