

<b>Case Number:</b>	CM15-0117339		
<b>Date Assigned:</b>	06/25/2015	<b>Date of Injury:</b>	06/28/2014
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	06/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/17/2015

### 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 Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 50 year old male who sustained an industrial injury on 06/28/14. Initial complaints and diagnoses are not available. Treatments to date include medications, physical therapy, a steroid injection into her left hip and home exercises. Diagnostic studies include a MRI and x-rays of the left knee, as well as MRIs of the lumbar spine and right hip. Current complaints include [pain in the lower back, right hand, right hip and left knee. Current diagnoses include lumbar facet syndrome, low back, hip, ad knee pain. In a progress note dated 06/01/15 the treating provider reports the plan of care as a second orthopedic opinion for her left knee, psychologist consultation, and medications including Lidoderm patches, gabapentin, trazodone, and MS Contin. Also recommended are physical therapy to the lower back, right hip and left knee, and a urine drug screen. The requested treatments include gabapentin, trazodone, and Lidoderm.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 600 mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
 Page(s): 16-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49.

**Decision rationale:** According to MTUS guidelines, "Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain". There was no documentation that the patient is suffering from neuropathic pain including diabetic neuropathic pain or post-herpetic neuralgia condition. There is no documentation of efficacy and safety from previous use of Gabapentin. Therefore, the prescription of Gabapentin 600mg #30 is not medically necessary.

**Trazodone 100 mg #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), insomnia treatment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Schwartz, T., et al. (2004) "'A comparison of the effectiveness of two hypnotic agents for the treatment of insomnia.'" Int J Psychiatr Nurs Res 10(1): 1146-1150.

**Decision rationale:** There is no clear evidence that the patient was diagnosed with major depression requiring Trazodone. There is no formal psychiatric evaluation documenting the diagnosis of depression requiring treatment with Trazodone. In addition, there is no documentation of failure of first line treatments for insomnia and depression. Therefore, the request for Trazodone 100mg #30 is not medically necessary.

**Lidoderm 5% patch #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57, 111-112.

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

**Decision rationale:** According to MTUS guidelines, "Lidoderm is the brand name for a lidocaine patch produced by [REDACTED]. 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". In this case, there is no documentation that the patient developed neuropathic pain that did not respond to first line therapy and the need for Lidoderm patch is unclear. There is no documentation of efficacy of previous use of Lidoderm patch. Therefore, the prescription of Lidoderm patches #30 is not medically necessary.