

Case Number:	CM15-0179247		
Date Assigned:	09/21/2015	Date of Injury:	07/28/1994
Decision Date:	11/16/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	09/11/2015

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: California, Arizona, Maryland
 Certification(s)/Specialty: Psychiatry

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 male with an industrial injury dated 07-28-1994. Medical record review indicates he is being treated for sacroiliac joint dysfunction, facet arthropathy, thoracic-lumbar, lumbar radiculopathy - right, failed back surgery syndrome, depression, chronic pain and shoulder impingement syndrome - right. Prior surgery included lumbar spine surgery, bilateral knee arthroscopic surgery and right shoulder surgery. He presents on 08-20-2015 with "severe" pain in the lower back down the left leg. The treating physician documented the patient was taking Norco 10-325 mg 8 per day and stated "it barely takes the edge off." "Pain interferes with sleep, activities of daily living, emotions and function." Pain rating is documented as 7 out of 10 "on a good day" and 10 out of 10 "on a bad day." Prior progress notes dated 04-23-2015 and 06-18-2015 document the pain rating as 7 out of 10 "on a good day" and 10 out of 10 "on a bad day." Current medications are listed as Androgel pump, Norco, Voltaren, Cyclobenzaprine, Lidoderm patch, Lisinopril-Hydrochlorothiazide. Review of the medical records indicates the injured worker has been on the above medications since 03-16-2015. Physical exam findings are documented as positive Hawkins and Neer on the right side (cervical spine), tenderness midline of mid thoracic spine and "severe tenderness over the right sacroiliac joint." Sensation to pinprick and light touch are documented as decreased in the right lower extremity. The most recent drug screen is dated 08-20-2015. The treatment request is for: Voltaren Gel 1% #3 times 1 refill, Psychological evaluation/treatment, Psychiatrist evaluation/treatment, Lidoderm patch 5% #90 times 1 refill, Androgel pump 20.25 1.62% #1 times 1 refill. On 08-31-2015 utilization review denied the request for: Voltaren Gel 1% #3

times 1 refill, Psychological evaluation/treatment, Psychiatrist evaluation/treatment, Lidoderm patch 5% #90 times 1 refill, Androgel pump 20.25 1.62% #1 times 1 refill.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychological evaluation/treatment: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Ankle and Foot Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological treatment.

Decision rationale: California MTUS states that behavioral interventions are recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. ODG Cognitive Behavioral Therapy (CBT) guidelines for chronic pain recommends screening for patients with risk factors for delayed recovery, including fear avoidance beliefs. Initial therapy for these "at risk" patients should be physical medicine for exercise instruction, using cognitive motivational approach to physical medicine. Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone: Initial trial of 3-4 psychotherapy visits over 2 weeks, With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions). Upon review of the submitted documentation, it is gathered that the injured worker suffers from chronic pain secondary to industrial trauma and would be a good candidate for behavioral treatment of chronic pain. However, the request for Psychological evaluation/treatment does not specify the number of sessions being requested and thus is not medically necessary at this time.

Psychiatrist evaluation/treatment: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Stress-Related Conditions 2004, Section(s): Treatment.

Decision rationale: ACOEM guidelines page 398 states: "Specialty referral may be necessary when patients have significant psychopathology or serious medical comorbidities." The most recent progress report dated 8/20/2015, the injured worker has been experiencing back pain radiating to the leg and there is note of depression and anxiety. However, there is no detailed information of these symptoms. There is also no information regarding the treatment so far for these symptoms by the primary treating physician. The request for Psychiatrist evaluation/treatment is not medically necessary based on above reasons.

Lidoderm patch 5% #90 times 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines p112 states Lidocaine Indication: Neuropathic pain, 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). 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. The medical records submitted for review do not indicate that there has been a trial of first-line therapy (tri-cyclic or SNRI antidepressants or an AED). There is also no diagnosis of diabetic neuropathy or post-herpetic neuralgia. As such, lidoderm is not recommended at this time. The request is not medically necessary.

Voltaren Gel 1% #3 times 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: With regard to topical NSAIDs, MTUS states "These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. (Mason, 2004) Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks)." Voltaren Gel 1% specifically is "Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist)." Per the guidelines, the indications of this medication are limited to joints that are amenable to topical treatment. The documentation submitted for review does not denote any indications for the request. The request is not medically necessary.

Androgel pump 20.25 1.62% #1 times 1 refill: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) FDA.gov: Androgel.

Decision rationale: Per FDA. gov: Testosterone Gel 1% is indicated for replacement therapy in adult males for conditions associated with a deficiency or absence of endogenous testosterone: Primary hypogonadism (congenital or acquired): testicular failure due to conditions such as cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals. These men usually have low serum testosterone concentrations and gonadotropins (follicle- stimulating hormone [FSH], luteinizing hormone [LH]) above the normal range. Hypogonadotropic hypogonadism (congenital or acquired): gonadotropin or luteinizing hormone-releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. These men have low testosterone serum concentrations, but have gonadotropins in the normal or low range. The request for Androgel pump 20.25 1.62% #1 times 1 refill is not medically necessary as there is no information suggesting that the injured worker suffers from conditions for which this treatment is indicated by FDA.