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| Case Number: | CM15-0067126 | | |
| Date Assigned: | 04/14/2015 | Date of Injury: | 06/09/2007 |
| Decision Date: | 05/13/2015 | UR Denial Date: | 03/13/2015 |
| Priority: | Standard | Application Received: | 04/08/2015 |

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: Arizona, California

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 56-year-old female who sustained an industrial fall injury on 06/09/2007. The injured worker was diagnosed with cervical myospasm and radiculopathy, status post lumbar fusion and status post right total knee arthroplasty. The injured worker underwent right knee surgery in 2008, 2010, a total knee replacement in 2013 and a two level decompression fusion in October 2008. Treatment to date has included diagnostic testing, surgery, physical therapy, injections, knee brace and medications. According to the primary treating physician's progress report on February 19, 2015, the injured worker continues to experience neck, lower back and left knee pain. The injured worker rates her neck pain as an 8/10 with no overall improvement since last visit. Her low back pain is rated 8/10, which improved from last visit of 10/10, and the left knee is a 9/10 with radiation behind the knee to the 3rd and 4th toes. Examination of the neck demonstrated decreased flexion and side to side bending range of motion without radiculopathy or sensory disturbances and full motion of the upper extremities. The lower back has decreased range of motion with spotty sensory loss in the dorsum of the left foot and slight swelling in the medial area of the right ankle from a recent slip and fall. The left knee has excellent motion, slight clicking and no instability. The injured worker has a non-antalgic gait and uses a cane for ambulation. A urine drug screening from December 2014 was negative for prescribed Hydrocodone. Current medications are listed as Norco, Lidoderm Patch, Lexapro and Voltaren Gel. The injured worker is Permanent and Stationary (P&S). Treatment plan consists of continuing with prescribed pain management and the current request for Hydrocodone, Lidoderm and Lexapro.

IMR ISSUES, DECISIONS AND RATIONALES

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

One month supply of hydrocodone 10/325 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 82-92.

Decision rationale: Hydrocodone is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Hydrocodone for over a year without significant improvement in pain or function. There were inconsistencies in the urine testing as noted in the history above. The continued use of Hydrocodone is not medically necessary.

One month supply of Lidoderm patches: Upheld

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

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

Decision rationale: According to the MTUS guidelines, topical analgesics are recommended as an option as indicated below. They are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Lidocaine is 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). Lidoderm has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. In this case, the claimant did not have the above diagnoses. Long-term use of topical analgesics such as Lidoderm patches are not recommended. The claimant was non-Lidoderm for over a year without significant pain or functional improvement. The request for continued and long-term use of Lidoderm patches as above is not medically necessary.

One month supply of Lexapro 10 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants Page(s): 13. Decision based on Non-MTUS Citation ODG and Mental pg 18.

Decision rationale: According to the guidelines, tricyclic antidepressants may be used as 1st line for pain. Lexapro is an SSRI anti-depressant. This medication was used for depression in this case. However, the last several months of notes do not indicate any information of medication response or details on mood /depression. There was no mention that the Lexapro is benefitting the claimant's pain. The request for continuing Lexapro is not justified and not medically necessary.