

Case Number:	CM15-0075579		
Date Assigned:	04/27/2015	Date of Injury:	05/28/2011
Decision Date:	07/02/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	04/20/2015

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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 40 year old male, who sustained an industrial injury on 5/28/11. The injured worker has complaints of low back pain with persistent bilateral lower extremity pain right more than left; mid-back pain between shoulder blade on and off radiating up neck; abdominal pain and right shoulder pain. The diagnoses have included possible lumbar diskogenic pain/possible bilateral lumbar facet pain L4-L5, L5-S1 (sacroiliac) right more than left/possible lumbar sprain/strain/status post L5-S1 (sacroiliac) lumbar laminectomy with discectomy on 12/14/12 with no improvement as of 7/17/13; bilateral lumbosacral radicular pain right more than right; cervical sprain/strain/thoracic sprain/strain/possible referred pain from lumbar spine and right shoulder sprain/strain. Treatment to date has included lansoprazole; Cymbalta; ambien; Norco and Lidoderm patch; status post L5-S1 (sacroiliac) lumbar laminectomy with discectomy; epidural block injections; magnetic resonance imaging (MRI) of the lumbar spine; physical therapy and chiropractic treatment. The request was for docusate sodium; Lidoderm patch; Norco and gabapentin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Docusate Sodium 250mg #60 Refills: 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page(s): 77.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioid Induced Constipation Treatment.

Decision rationale: Regarding the request for Docusate, California MTUS does not contain criteria regarding constipation treatment. ODG states that opioid induced constipation is recommended to be treated by physical activity, maintaining appropriate hydration, and following a diet rich in fiber. Over-the-counter medication such as stool softeners may be used as well. Second line treatments include prescription medications. Within the documentation available for review, there are no recent subjective complaints of constipation. There is no statement indicating whether the patient has tried adequate hydration, well-balanced diet, and activity to reduce the complaints of constipation should they exist. Additionally, there is no documentation indicating how the patient has responded to treatment with docusate. In the absence of such documentation, the currently requested docusate is not medically necessary.

Lidoderm patch #30 Refills: 2: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 page(s): 112 of 127.

Decision rationale: Regarding request for topical Lidoderm, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Additionally, there is no documentation of analgesic effect or objective functional improvement as a result of the currently prescribed Lidoderm. Finally, there is no documentation of localized peripheral pain as recommended by guidelines. As such, the currently requested Lidoderm is not medically necessary.

Norco 10/325mg #120 Refills: 0: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids page(s): 91, 78-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Norco (Hydrocodone/acetaminophen), California Pain Medical Treatment Guidelines state that Norco is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, regarding any aberrant use. Guidelines go on to recommend discontinuing opioids

if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Norco (Hydrocodone/acetaminophen) is not medically necessary.

Gabapentin 600mg #180 Refills: 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs page(s): 16, 18, 19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 page(s): 16-21 of 127.

Decision rationale: Regarding request for gabapentin (Neurontin), Chronic Pain Medical Treatment Guidelines state that anti-epilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS), and no documentation of specific objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. In the absence of such documentation, the currently requested gabapentin (Neurontin) is not medically necessary.