

Case Number:	CM15-0095727		
Date Assigned:	05/22/2015	Date of Injury:	04/01/1993
Decision Date:	06/26/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	05/18/2015

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
 Certification(s)/Specialty: Emergency 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 22 year old male who sustained an industrial injury on 04/01/1993. Current diagnoses include postlaminectomy syndrome of lumbar region, lumbar or lumbosacral disc degeneration, thoracic or lumbosacral neuritis or radiculitis, and unspecified myalgia and myositis. Previous treatments included medication management, and gym membership. Report dated 04/06/2015 noted that the injured worker presented with complaints that included back pain, joint pain, joint stiffness, limb pain, muscle spasms, numbness and tingling. Pain level was 5 out of 10 (best), and 8 out of 10 (worst) on a visual analog scale (VAS). Physical examination was positive for restricted range of motion due to pain, spasms, tight muscle band, spinous process tenderness, unable to heel or toe walk, straight leg test is positive on the right, and muscle strength test is limited by pain. The treatment plan included continue with independent exercise program, and discontinue all medications except Norco. Disputed treatments include Lidoderm patches, hydrocodone/acetaminophen, simvastatin, and ketoprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patch 5% #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm, Pages 56-57 Page(s): 56-57.

Decision rationale: The requested Lidoderm patch 5% #30, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Lidoderm, Pages 56-57, note that "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 or Lyrica)". It is not considered first-line therapy and only FDA approved for post-herpetic neuralgia. The injured worker has back pain, joint pain, joint stiffness, limb pain, muscle spasms, numbness and tingling. Pain level was 5 out of 10 (best), and 8 out of 10 (worst) on a visual analog scale (VAS). Physical examination was positive for restricted range of motion due to pain, spasms, tight muscle band, spinous process tenderness, unable to heel or toe walk, straight leg test is positive on the right, and muscle strength test is limited by pain. The treating physician has not documented, failed first-line therapy or documented objective evidence of functional improvement from the previous use of this topical agent. The criteria noted above not having been met, Lidoderm patch 5% #30 is not medically necessary.

Hydrocodone-acetaminophen 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82 Page(s): 78-82.

Decision rationale: The requested Hydrocodone-acetaminophen 10/325mg #120, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has back pain, joint pain, joint stiffness, limb pain, muscle spasms, numbness and tingling. Pain level was 5 out of 10 (best), and 8 out of 10 (worst) on a visual analog scale (VAS). Physical examination was positive for restricted range of motion due to pain, spasms, tight muscle band, spinous process tenderness, unable to heel or toe walk, straight leg test is positive on the right, and muscle strength test is limited by pain. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Hydrocodone-acetaminophen 10/325mg #120 is not medically necessary.

Simvastatin 20mg #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), Diabetes, Statins.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/simvastatin.html>.

Decision rationale: The requested Simvastatin 20mg #30, is not medically necessary. CA MTUS and ODG are silent on this issue. <http://www.drugs.com/pro/simvastatin.html> recommends this lipid agent for high cholesterol. The injured worker has back pain, joint pain, joint stiffness, limb pain, muscle spasms, numbness and tingling. Pain level was 5 out of 10 (best), and 8 out of 10 (worst) on a visual analog scale (VAS). Physical examination was positive for restricted range of motion due to pain, spasms, tight muscle band, spinous process tenderness, unable to heel or toe walk, straight leg test is positive on the right, and muscle strength test is limited by pain. The treating physician has not documented the current lipid levels nor functional improvement from previous use. The criteria noted above not having been met, Simvastatin 20mg #30 is not medically necessary.

Ketoprofen 10% #1 tube: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-steroidal anti-inflammatory agents, Page 111-112; Non-steroidal anti-inflammatory medications, GI symptoms and cardiovascular risk, Page 68-69.

Decision rationale: The requested Ketoprofen 10% #1 tube, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Topical Analgesics, Non-steroidal anti-inflammatory agents, Page 111-112, recommend topical analgesics with documented osteoarthritis with intolerance to oral anti-inflammatory agents; Non-steroidal anti-inflammatory medications, GI symptoms and cardiovascular risk, Page 68-69, note that all NSAIDs have the potential to raise blood pressure in susceptible patients. The injured worker has back pain, joint pain, joint stiffness, limb pain, muscle spasms, numbness and tingling. Pain level was 5 out of 10 (best), and 8 out of 10 (worst) on a visual analog scale (VAS). Physical examination was positive for restricted range of motion due to pain, spasms, tight muscle band, spinous process tenderness, unable to heel or toe walk, straight leg test is positive on the right, and muscle strength test is limited by pain. The treating physician has not documented the patient's intolerance of these or similar medications to be taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Ketoprofen 10% #1 tube is not medically necessary.