MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270

MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 11/19/2013

[redacted]

[redacted]

Employee:	[redacted]
Claim Number:	
Date of UR Decision:	7/24/2013
Date of Injury:	8/2/2007
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0006608

1) **MAXIMUS Federal Services, Inc. has determined the request for Lidoderm 5% is medically necessary and appropriate.**

2) **MAXIMUS Federal Services, Inc. has determined the request for Neurontin 600mg #90 is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/24/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/27/2013. A decision has been made for each of the treatment and/or services that were in dispute:

1) **MAXIMUS Federal Services, Inc. has determined the request for Lidoderm 5% is medically necessary and appropriate.**

2) **MAXIMUS Federal Services, Inc. has determined the request for Neurontin 600mg #90 is medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:
The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Neurology, has a subspecialty in headaches and is licensed to practice in California. 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 treatments and/or services at issue.

Expert Reviewer Case Summary:
The patient is a 60 year old woman injured 8/2/2007, being treated for chronic low back pain. There has been radiating pain to the left leg, persistent despite lumbar surgery June 2012, and with reported flare up of pain sine May 2013. Examination reported L5 weakness and hypersensitivity, with diagnosis of lumbosacral spondylosis, lumbago and radiculitis. Coverage for Lidoderm was denied, and coverage for Neurontin was modified to only allow taper and discontinuation.

Documents Reviewed for Determination:
The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) **Regarding the request for Lidoderm 5%:**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Lidoderm (Lidocaine patch), which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Lidoderm, pg. 56, and Topical analgesics, pg. 112, which are part of the MTUS.

Rationale for the Decision:
This employee has localized pain and radicular pain, which is generally felt to reflect a neuropathic component. Guidelines indicate that Lidoderm 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). This employee has had first line therapy for a number of years, and has both localized pain across the back, and radiating pain to the leg. The employee has been on gabapentin as well. Use of Lidoderm is appropriate per guidelines. **The request for Lidoderm 5% is medically necessary and appropriate.**

2) **Regarding the request for Neurontin 600mg #90:**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Neurontin (gabapentin), which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Antiepilepsy drugs, pgs. 16, 18, and Medications for chronic pain, pg. 60, which are part of the MTUS.

Rationale for the Decision:
Gabapentin is widely used in management of chronic pain. In guidelines, it is recommended for peripheral neuropathy, central pain, and CRPS. It is noted in spinal stenosis to have resulted in produced statistically significant improvement in walking distance, decrease in pain with movement and sensory deficit. It is considered first-line treatment for neuropathic pain.

Regarding chronic lumbar root pain, guidelines state that opioids are considered a second-line treatment for several reasons: (1) head-to-head comparisons have found that opioids produce more side effects than TCAs and gabapentin; guidelines also note fairly good evidence that the use of gabapentin and gabapentin-like compounds results in decreased opioid consumption.

This employee has chronic pain with radicular, neuropathic components. Gabapentin is appropriate per guidelines. **The request for Neurontin 600mg #90 is medically necessary and appropriate.**

Effect of the Decision:
The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/ldh

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.