

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/19/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/31/2013
Date of Injury: 5/22/2007
IMR Application Received: 8/9/2013
MAXIMUS Case Number: CM13-0009060

Dear [REDACTED]:

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Cardiology, has a subspecialty in Fellowship Trained in Cardiovascular Disease 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 physician 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/services.

DOCUMENTS REVIEWED

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

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 65-year-old female who reported a work-related injury on 05/22/2007, specific mechanism of injury not stated. The patient presents for treatment of the following diagnoses: chronic pain to the lumbar spine; status post lumbar surgery failed back syndrome; postsurgical spinal arachnoiditis; and lumbar spine spinal cord stimulator, permanent placement 08/21/2013. The clinical note dated 09/11/2013 reported that the patient was seen in clinic under the care of Dr. [REDACTED]. The provider documented that the patient presented postoperative to spinal cord stimulator implantation with complaints of increasing low back pain and hip pain. The patient reported continued headaches, depression and low back pain radiating to the left lower extremity with numbness. The patient reported forgetfulness with decreased concentration and memory. Upon physical exam of the patient, there was a positive straight leg raise to the left at 60 degrees and to the right at 40 degrees, decreased range of motion and lumbar spine spasm. Electrodiagnostic studies of the bilateral lower extremities revealed a right L3-4 radiculopathy. The patient utilized Neurontin 600 mg 5 times a day and Savella 50 mg twice a day. The provider documented that the patient was to utilize Lidoderm patches for the thoracic and lumbar spine pain, continue with CPAP at home, followup with pain management for spinal cord stimulator efficacy.

IMR DECISION(S) AND RATIONALE(S)

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

1. Lidoderm patches between 7/24/2013-9/13/2013 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Lidoderm (lidocaine patch), pages 56-57, which are part of the MTUS.

The Physician Reviewer's decision rationale:

The current request previously received an adverse determination due to a lack of support of utilization of this topical analgesic after review of the California MTUS Guidelines. In addition, the employee utilizes Neurontin 600 mg 5 times a day. Lidoderm is only FDA-approved for the treatment of postherpetic neuralgia. The California MTUS indicates, "Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of a first-line therapy, tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica." The clinical notes lack rationale to support the current request. The employee utilizes both an oral medication for neuropathic pain and a topical for neuropathic pain. **The request for Lidoderm patches between 7/24/2013-9/13-2013 is not medically necessary and appropriate.**

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.



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