

Case Number:	CM13-0044681		
Date Assigned:	12/27/2013	Date of Injury:	10/14/2003
Decision Date:	02/25/2014	UR Denial Date:	10/11/2013
Priority:	Standard	Application Received:	10/31/2013

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 Pain Management, has a subspecialty in Disability Evaluation 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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

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

According to the medical records, the patient is a retired 60-year-old female attorney for the [REDACTED] who sustained an industrial injury on October 14, 2003. The patient is status post a right shoulder surgery in 2004, a left shoulder surgery in 2005, and has had surgery with fusions at C5-6 and C6-7 in 2007 followed by hardware removal in 2007. She has also undergone left carpal tunnel release and deQuervain's release. On September 10, 2010, the patient underwent a QME submitted by [REDACTED]. Future medical care stated that "the patient would require the use of analgesic and anti-inflammatory medications or muscle relaxers. The treatment being done by [REDACTED] is within the realm of medical care. I certainly do not have any objections, although I would have preferred having the patient kept off of narcotic medications. If in the future the patient decides to be weaned off of narcotics, then she probably would require a detoxification program. The patient does not require any additional surgery." A March 29, 2011 findings and award notes that further medical treatment is required to cure or relieve the effects of the injury. On August 2, 2011, the patient underwent a CT myelogram of the cervical spine, which demonstrated: "successful cervical myelogram performed without complication. The patient is status post anterior cervical fusion at CS5-6 with intradiscal struts and successful postoperative fusion without hardware complication. Mild 2.5 mm diameter central and right paramedian disc protrusion at C3-4 might be abutting the ventral ramus for the right C4 nerve rootlet accounting for the patient's symptomatology, No true disc extrusion or free fragment is felt present. Mild areas of facet hypertrophy as detailed above. No bony foramina! stenosis, though, has occurred. A March 29, 2012 court order by [REDACTED] indicates that based on the reports of [REDACTED], it is felt that the applicant is in need of further treatment to cure or relieve the effects of the injury to the upper extremities, shoulders and neck A March 25, 2013 letter by [REDACTED] indicates that the patient recently underwent left carpal tunnel release and

deQuervain's release. According to the progress report of May 9, 2013, the cervical CT scan has shown a new finding. She continues to have neck pain with radiation the pain down her arms. She needs a surgical evaluation and possible intervention. The medications include Lidoderm patch 5% ooply 2 Q day #60..A May 21, 2013 report by [REDACTED] notes that the patient continues to have pain and discomfort, due to multiple medical problems, including a history of cervical spine surgery in 2007, right shoulder condition, bilateral carpal tunnel syndrome, and deQuervain's disease. She has been on OxyContin 30 mg t.i.d. #90, Norco 10/325 mg one q.i.d., and other medications to help her pain. The patient has managed to remain stable, however, continues to have pain and discomfort. A recommendation was made for the patient to see a spine surgeon for radiculitis with possible C4 impingement. On March 29, 2007, [REDACTED], ordered the patient to continue the pain medicines in a court order. The physician will try to wean the medicine as best as possible. [REDACTED] has also recommended pain medication. The physician felt that it was unlikely that the patient will be able to wean off medicines when she has an active cervical problem and had previous fusion with multiple other problems. A peer review was conducted on June 18, 2013 and the requested gabapentin, meloxicam and amitriptyline were certified. Morphine sulfate and Norco were recommended for weaning. Carisoprodol, Lidoderm 5% patches, pantoprazole and Tizanidine were non-certified. [REDACTED] reported on August 22, 2013. She reports no improvement in her neck and shoulder pain. There is tenderness in the paraspinal region and pain with ROM. She has "giving way" weakness. There is pain with shoulder abduction and flexion. She need

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm dis 5% (700mg) #30/15/0: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112 of 127.

Decision rationale: The patient have been prescribed amitriptyline and gabapentin which were approved on June 18, 2013. There is no indication that she is intolerant or unresponsive to these medications. She does not appear to have failed the recommended first line neuropathy medications. The area designated for treatment and the duration of use is not documented. The guideline states that there should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). According to CA-MTUS (Effective July 18, 2009) page 112, section of Topical Analgesics-Lidoderm patch whose active ingredient is; Lidocaine Indication: Neuropathic pain 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). ODG-TWC-Pain Treatment-Topical Analgesics. Lidoderm Patch: The FDA has approved a lidocaine/ tetracaine cream (Pliaglis®) for local analgesia. This is only indicated for superficial aesthetic procedures, such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. (FDA, 2013) Criteria for use of Lidoderm patches: (a) Recommended for a trial if there

is evidence of localized pain that is consistent with a neuropathic etiology. (b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). (c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. (d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale. (e) The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day). (f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks). (g) It is generally recommended that no other medication changes be made during the trial period. (h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued. (i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued.