

<b>Case Number:</b>	CM14-0004172		
<b>Date Assigned:</b>	02/03/2014	<b>Date of Injury:</b>	01/22/2010
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	12/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2014

### 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. The expert reviewer is Board Certified in Occupational Medicine 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 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:

Patient is a 40-year-old female who has submitted a claim for cervical facet generated pain with right upper extremity radiation, and impingement syndrome of right shoulder associated with an industrial injury date of 1/22/2010. Medical records from 2010-2013 were reviewed which revealed consistent right lower neck pain radiating to right shoulder and right biceps. Exacerbating factors include prolonged sitting, driving, writing and typing. Physical examination of the cervical spine showed restricted range of motion because of pain in all directions. Cervical extension was worse than cervical flexion. There were tenderness of the right biceps, right deltoid, right upper extremity extensor tendons, cervical paraspinal muscles overlying C2-C4 and right C4-C5 facet joints. Shoulder impingement test was positive on the right. Apprehension and supraspinatus isolation tests of the shoulder were negative bilaterally. Tendinitis and nerve root signs were negative bilaterally. Clonus, Babinski and Hoffman signs were absent bilaterally. MMT was 5/5 in bilateral upper extremities. Cervical spine and right shoulder MRI done on 04/19/2010 showed no acute findings. There was a nominal bulge at C7-T1. Treatment to date has included, 3 radiofrequency ablations and physical therapy sessions. Medications taken include, Zipsor 25 mg, Percocet 5/325 mg and Lyrica 50 mg/tab. Utilization review from 12/24/2013 denied the request for Medrol Dose Pack #1 and Lidoderm Patches 5% (#30) with 1 refill. Medrol Dose pack was denied because guidelines do not support the use of oral corticosteroids as an effective treatment for back pain. Lidoderm patch was denied because there must be evidence that a trial of first-line therapy failure prior to prescribing Lidoderm patch.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MEDROL DOSE PACK (QUANTITY # 1):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Anti-Inflammatory and Immunosuppressive Effects of Glucocorticoids, Recent Developments and Mechanistic Insights, Molecular And Cellular Endocrinology, 2011, 335 (1): 2-13 (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3047790/>)

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, an article from Molecular and Cellular Endocrinology was used instead. It states that synthetic glucocorticoids remain at the forefront of anti-inflammatory therapy. In this case, patient underwent radiofrequency nerve ablation (rhizotomy) on 11/14/2013, which resulted to worsening of her symptoms. The documented rationale for corticosteroid is to 'calm' the flare-up of symptoms associated with rhizotomy. The medical necessity for an anti-inflammatory agent has been established. Therefore, the request for Medrol Dose Pack (quantity #1) is medically necessary.

**LIDODERM PATCHES 5% ( # 30) WITH 1 REFILL:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidoderm.

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

**Decision rationale:** As stated on pages 56-57 of the California MTUS Chronic Pain Medical Treatment Guidelines, Lidoderm is 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). In this case, the patient has been taking Lyrica, a first-line therapy, since April 30, 2013, and reported improvement of symptoms. However, patient underwent radiofrequency nerve ablation (rhizotomy) on 11/14/2013, which resulted to worsening of her symptoms. The documented rationale for lidocaine patch is to provide a transdermal form of anesthesia at the site of rhizotomy. The medical necessity for a local form of treatment has been established. Therefore, the request for Lidoderm patch 5% #30 with 1 refill is medically necessary.