

<b>Case Number:</b>	CM14-0109320		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	10/03/2003
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	07/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Texas and Ohio. 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:

The injured worker is a 47 year old female who reported an injury on 10/03/2003; the mechanism of injury was not provided. Diagnoses included impingement of the right shoulder, cervical disc disorder with myelopathy, and lumbar disc disorder with myelopathy. Past treatment included lumbar epidural steroid injection. Diagnostic studies included an MRI of the lumbar spine, date unknown, which showed flattening L5-S1 and L4-5 discs, unofficial. Surgical history included right shoulder surgery in 2003. The clinical note dated 06/03/2014 indicated the injured worker complained of low back pain with numbness in the left leg. Physical exam findings indicated trapezial and cervical paraspinal muscle tenderness, positive straight leg raise, decreased achilles reflexes, neck extension of 15 degrees, and flexion of 20 degrees. The exam also revealed weakness in the right shoulder in flexion and abduction, and weakness and catching in lowering the arm consistent with a rotator cuff tear and subacromial spurring. Current medications included gabapentin 100 mg, Tylenol 500 mg, naproxen 500 mg, Voltaren 1% topical gel, and Lidoderm 5% patch. The treatment plan included Lidoderm patch and Voltaren gel; the rationale for treatment was not provided. The request for authorization form was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidocaine Pad (lidoderm) 5 percent (700mg/patch) adhesive patch #90 with 3 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

**Decision rationale:** The injured worker complained of low back pain with numbness in the left leg, with physical exam findings of trapezial and cervical paraspinal muscle tenderness. The California MTUS guidelines state that topical anaglesics are largely experimental in use with few randomized controlled studies to determine efficacy and safety, and are primarily recommended for neuropathic pain when trials of antidepressants and anticonculsants have failed. Lidocaine is indicated for neuropathic pain and 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). The guidelines go on to state that topical lidocaine, in the formulation of a dermal patch Lidoderm has been designated for orphan status by the FDA for neuropathic pain. The injured worker complained of low back pain with numbness in the left leg. There is no evidence of first-line medication therapy, and the request does not include instructions for use of the lidoderm patch. The request for refills would not be indicated as the efficacy of the medication should be assessed prior to providing additional medication. Therefore at this time, the request for lidoderm patch is deemed not medically necessary.

**Voltaren gel 1 percent topical gel #1 with 5 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

**Decision rationale:** The injured worker complained of low back pain with numbness in the left leg, with physical exam findings of trapezial and cervical paraspinal muscle tenderness. The California MTUS guidelines state that topical anaglesics are largely experimental in use with few randomized controlled studies to determine efficacy and safety, and are primarily recommended for neuropathic pain when trials of antidepressants and anticonculsants have failed. The guidelines state that Voltaren gel 1% is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee and wrist), and has not been evaluated for treatment of the spine, hip or shoulder. While the request does not specifically state where the gel is to be used, the injured worker complained of pain to the low back. There are no clinical or diagnostic findings to indicate osteoarthritis, and the request does not include instruction for use of the gel. The request for refills would not be indicated as the efficacy of the medication should be assessed prior to providing additional medication. Additionally, the guidelines state that Voltaren gel 1% has not been evaluated for treatment of the spine. As such, the request at this time is deemed not medically necessary.

