

<b>Case Number:</b>	CM14-0118760		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	06/13/2003
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	07/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2014

### 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 & Rehabilitation, 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:

The injured worker is a 55-year-old female who reported an injury on 06/13/2003. The mechanism of injury was not provided. Prior studies included an MRI of the lumbar spine. The injured worker's medication history included Lidoderm patches and antiepileptic medications in 2012. The prior treatments included physical therapy, epidural steroid injections, and a Functional Restoration Program, as well as medications. The documentation of 06/12/2014 revealed the injured worker had chronic low back pain and bilateral lower extremity pain and was utilizing a home exercise program. The injured worker indicated that with the medications she could exercise better and perform her activities of daily living better. There were noted to be no side effects. The objective findings revealed the injured worker had tenderness to palpation at the lumbosacral junction, right greater than left and a positive straight leg raise on the right. The sensation was decreased to light touch along the right lower extremity compared to the left and deep tendon reflexes were absent at the bilateral patella and 1+ and equal at the Achilles. The current medications were noted to be Lidoderm patches 5% patches, Gabapentin 600 mg tablets, Hydrocodone /APAP 10/325 mg, and Cyclobenzaprine 5 mg tablets. The diagnosis included lumbar disc displacement without myelopathy, sciatica and long term use meds necessary. The treatment plan included refilling medications. There was a DWC Form RFA for the requested medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm 5% Patch (700mg/patch) #90n with 3 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California Chronic Pain Medical Treatment Guidelines.

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

**Decision rationale:** The California MTUS guidelines indicate that topical Lidocaine (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 is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. No other commercially approved topical formulations of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review indicated the injured worker had utilized the medication since 2012. There was a lack of documentation of objective functional benefit and an objective decrease in pain with the use of the medication. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating a necessity for 3 refills without re-evaluation. Given the above, the request for Lidoderm 5% patch 700 mg/patch #90n with 3 refills is not medically necessary.

**Gabapentin 600mg #120 with 5 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California Chronic Pain Medical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): page 16.

**Decision rationale:** The California MTUS Guidelines recommend antiepileptic as a first line medication for the treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30% to 50% and objective functional improvement. The clinical documentation submitted for review failed to meet the above criteria. The documentation indicated the injured worker had utilized the medication since 2012. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating a necessity for 5 refills without re-evaluation. Given the above, the request for Gabapentin 600 mg #120 with 5 refills is not medically necessary.