

<b>Case Number:</b>	CM14-0119896		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	06/06/2014
<b>Decision Date:</b>	12/31/2014	<b>UR Denial Date:</b>	07/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2014

### 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 Family 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:

This 47-year old woman apparently reported injuries to her neck, spine and right thumb due to repetitive stress in the course of her usual work activities, date of injury 6/6/14. She has not worked since her injury. The available record contains a single report from the treater, a Doctor's First Report, dated 6/24/14. It notes that the patient has had neck and shoulder pain radiating to the right thumb for one year. She also claims to have an acute stress disorder and that she woke up with a black eye from stress. A very limited exam is recorded which includes tenderness and decreased range of motion of the neck, weakness of the right thumb, and decreased sensation of the right hand. The patient is agitated and anxious. Diagnoses include degenerative cervical spine stenosis and anxiety. The available records do not contain any information about what medications were dispensed or why they were dispensed. According to a UR report from 7/8/14, medications dispensed at the 6/24/14 visit included Lidoderm patches, hydrocodone/APAP and lorazepam. All three medications were non-certified in the 7/8/14 UR.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidocaine pad 5%, Day Supply: 20, QTY: 20 with no refills:** 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 Medications for Chronic Pain, Topical analgesics, Lidoderm (lidocaine patch) Page(s): 60; 112; 5.

**Decision rationale:** The first reference cited above states that medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. According to the other MTUS citations above, Lidoderm is indicated for localized neuropathic pain if there is evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Only FDA-approved products are indicated, and no other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Topical lidocaine is not indicated for non-neuropathic pain. Lidoderm patches are only FDA-approved for post-herpetic neuralgia. The clinical findings in this case do not support the use of Lidoderm patches. Lidoderm is being started with two other medications, which means it cannot be monitored individually and it would be impossible to tell which medication caused any side effect or functional improvement that might result. This patient does not have any documentation of a diagnosis of neuropathic pain or of a trial of first-line therapy for neuropathic pain. Based on the MTUS citations above and on the clinical records provided for my review, Lidocaine/Lidoderm patches 5% # 20 are not medically necessary. They are not medically necessary because there is no documentation of appropriate indications for their use, and because they are being started simultaneously with two other medications.

**Hydrocodone /APAP 7.5-325mg, Day Supply: 8, QTY: 30 with no refills:** 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 Medications for Chronic Pain, Criteria for use of Opioids, Opioids for neuropathic pain Pag.

**Decision rationale:** Hydrocodone/APAP is an analgesic containing hydrocodone, which is an opioid, and acetaminophen. According to the first guideline cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. The remaining guidelines state that opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine in the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. There are very limited numbers of studies that involve opioid treatment for chronic lumbar root pain. A recent study found that chronic radicular lumbar pain did not respond to opioids in doses that have been effective for painful diabetic neuropathy and postherpetic neuralgia. The clinical documentation in this case does not support the provision of hydrocodone/APAP to this patient. Since its use is

being documented in a Doctor's First Report, it is presumable being started and not continued. It is being started with two other medications, which means it cannot be monitored individually and it would be impossible to tell which medication caused any side effect or functional improvement that might result. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. The documented symptoms as well as the provision of Lidoderm to this patient, make it appear that the patient's pain is neuropathic. Neuropathic pain does not necessarily respond well to opioids. No assessment was made of whether or not opioid use was likely to be helpful in this patient, or of her potential for abuse. No specific functional goals were set for the use of this opioid. Based on the MTUS citations above as well as on the clinical documentation provided for my review, hydrocodone/APAP 7.5/325 mg #30 is not medically necessary. It is not medically necessary because it is being started with two other medications, because there is no documentation of whether or not this medication is appropriate for this patient, or that functional goals were set for its use.

**Lorazepam tab 1mg, Day Supply: 10, QTY: 30 with no refills: 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 Medications for Chronic Pain, Benzodiazepines Page(s): 60; 24.

**Decision rationale:** Lorazepam is a benzodiazepine. According to the first guideline cited above, medications should be started individually while other treatments are held constant, with careful assessment of function. There should be functional improvement with each medication in order to continue it. Per the benzodiazepine citation above, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit us to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic anticonvulsant and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. The clinical documentation in this case does not support the provision of lorazepam to this patient. It is being started with two other medications, which means it cannot be monitored individually and it would be impossible to tell which medication caused any side effect or functional improvement that might result. The patient was given a diagnosis of anxiety based on virtually no documented data, and was presumably given lorazepam to treat it. Assuming that she in fact has an anxiety disorder, the reference cited above makes it clear that lorazepam is not the appropriate treatment for anxiety, especially in the long term. A more appropriate choice would have been an antidepressant. Based on the MTUS citations above and on the clinical documentation provided for my review, lorazepam 1 mg #30 is not medically necessary. It is not medically necessary because it is being started with two other medications, because it is not clear that a careful evaluation was made for anxiety, and because even if the patient has an anxiety disorder lorazepam would not be the drug of choice for it.