

<b>Case Number:</b>	CM14-0124633		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	03/17/2003
<b>Decision Date:</b>	09/12/2014	<b>UR Denial Date:</b>	07/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/06/2014

### 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 Texas & Oklahoma. 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 43-year-old female who reported an injury on 03/17/2003 due to an unknown mechanism. Diagnoses were degeneration of lumbar or lumbosacral intervertebral disc, lumbago, other symptoms referable to back, displacement of lumbar intervertebral disc without myelopathy, spasm of muscle, myalgia and myositis, unspecified, thoracic or lumbosacral neuritis or radiculitis, unspecified, chronic pain syndrome, and lumbar facet joint pain. Past treatment was bilateral facet block on 02/11/2014 with a 50% pain relief lasting a month. Also, radiofrequency rhizotomy on 2006, and chiropractic sessions. Diagnostics were a lumbar MRI. Surgical history was not reported. Physical examination on 07/03/2014 revealed reports of pain 9/10 without medications and with medication it was rated a 7-8/10. The injured worker reported current pain level interfered with her daily activities and overall function. Examination of the lumbar spine revealed positive straight leg raise bilaterally. There was tenderness with palpation bilateral L4-5, right more than left. Palpation of the lumbar spine demonstrated maximum tenderness along the midline lumbar spine. Flexion did provide a complaint of pain, extension was positive. Left supine straight leg raise was positive at 40 degrees, with complaint of low back pain radiating down left lateral thigh. Right supine straight leg raise was positive at 35 degrees with complaint of low back pain that radiated down right posterior lateral leg. Neuro exam revealed diffuse hypoesthesia posterior thighs and calves. Medications were Norco 10/325 mg 1 every 8 hours as needed, Neurontin 300 mg 1 four times a day, Lidoderm patch 2 daily, ibuprofen 800 mg 1 three times a day, and tramadol 50 mg 1 four times a day as needed for pain. Treatment plan was to request authorization for aqua therapy and trigger point injections, bilateral radiofrequency rhizotomy, L4-S1. The rationale and Request for Authorization were not submitted for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm 5% #30 x3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

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

**Decision rationale:** The California Medical Treatment Utilization Schedule 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 postherpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The efficacy of this medication was not reported. Past treatment modalities were not reported with functional improvement or failure. The request did not indicate a frequency for the medication. Therefore, the request is not medically necessary and appropriate.

**Gabapentin 300mg # 90 x3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19.

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that gabapentin is shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. The efficacy of this medication was not reported. The request submitted does not indicate a frequency for the medication. Therefore, the request for Gabapentin 300mg # 90 x3 refills is not medically necessary and appropriate.

**Motrin 800mg #90 x3 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Nonprescription Medications, Ibuprofen Page(s): 67.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend nonprescription medications including ibuprofen for the treatment of pain and inflammation. The efficacy of this medication was not reported. The request submitted does not indicate a frequency for the medication. Therefore, request for Motrin 800mg #90 x3 refills is not medically necessary and appropriate.