

Case Number:	CM14-0152279		
Date Assigned:	09/22/2014	Date of Injury:	09/11/2007
Decision Date:	10/29/2014	UR Denial Date:	09/08/2014
Priority:	Standard	Application Received:	09/18/2014

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 Georgia. 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 patient is a 51-year-old male who sustained a work related injury on 09/11/07. The mechanism of injury has not been documented in the record. Prior treatment history has included lumbar steroid epidural injection at L5-S1. The patient's medications as of 07/30/2014 included cyclobenzaprine (Flexeril) 10 mg, Gabapentin 800 mg, Norco 10/325, Anaprox, Prilosec and Lidoderm patch 5% with a VAS of 8/10 without medications and 6/10 with medications. The patient underwent arthroscopic medial meniscectomy; arthroscopic chondroplasty of patella, lateral tibial plateau and arthroscopic plica excision on 01/24/2014. Diagnostic studies were reviewed. An MRI report from 10/28/13 summary from the 08/28/14 progress report (PR) revealed a broad, 2-3 mm disc protrusion at L2-L3 which partially compromised both exiting nerve roots. At L3-L4, there was a broad 4-5 mm disc protrusion which was seen to bulge into both neural foraminal exit zones. High grade left and moderate to high-grade right neural foraminal exit zone compromise was seen. Posterior ligamentous hypertrophy was present. At L4-L5 there was a heterogenous, 5-6 mm disc protrusion which was midline and extended inferiorly along the posterior superior endplate of L5. This bulged into both neural foraminal exit zones. High grade foraminal exit zone compromise was seen. At L5-S1, a 3-4 mm disc protrusion extended into both neural foraminal zones, with high-grade bilateral neural foraminal exit zone compromise noted. A summary of EMG/NCV findings from 10/29/13 included in the 08/28/14 PR was reviewed. Absent sensory action potentials were noted as being present in the bilateral sural nerves. Borderline prolonged H reflex latency noted on the right side. Poorly formed H-reflex latency was noted on the right side. A poorly formed H-reflex potential was noted on the left side. On the PR dated 7/30/2014, medications listed were Flexeril for acute flare ups of spasms and Naproxen for inflammation, Omeprazole for GI upset from chronic NSAID use and Gabapentin for neuropathic pain. The patient was able to walk longer

and get around the house better with the help of his medications. He rated the pain as 8/10 without medication and 6/10 with medication. He had increased spasm and inflammation in his low back which had been bothering him. Objective findings during examination revealed the patient had 4+/5 strength in his right lower extremity and 5/5 strength in the left lower extremity. Sensation was intact, but decreased over the right lower extremity in the L5 and S1 dermatome. There was tenderness over the paraspinal muscles on the right of the lumbar spine. There was increased pain with flexion and extension. SLR was positive on the right. The patient was diagnosed with radiating low back pain to the right leg, lumbar radiculopathy, numbness, lumbar degenerative disc disease, and lumbar discogenic pain. The patient was recommended to continue Lidoderm 5% patch, #60. PR dated 08/28/2014 reported the patient presented with low back pain. He reported continued his medications have been helpful and well tolerated. He was taking flexeril for acute flare ups of muscle spasms, norco for severe pain, naproxen for inflammation, omeprazole for GI upset from chronic NSAID use, gabapentin for neuropathic pain, and Lidoderm patches for flare-ups of pain. He reported he was able to walk longer and help out more around the house with the help of his medications. The patient described burning pain in the right low back, right buttock, and right thigh. He reported numbness over his right lower extremity as well. The pain was worse with sitting, standing, walking, bending, and lifting. Pain is reported as better with medications, TENS unit, and laying down. He rated the pain as 8/10 on a VAS without medications, and 6/10 with. Pain reported worse since prior appointment. Denied any new neurologic changes or symptoms since prior visit. He reported increased spasms and inflammation in his low back.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patches 5% QTY: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch) - Topical lidocaine; (See also, Top.

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

Decision rationale: The California Medical Utilization Treatment Schedule (MTUS) recommends that topical lidocaine in the form of Lidoderm patches may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants or an anti-epileptic drug such as gabapentin or Lyrica). Lidoderm patches are not first line treatment for peripheral pain, and Lidoderm is only FDA approved for post-herpetic neuralgia. The medical records do not document indications for treatment with Lidoderm patches. Based on the MTUS guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.