

<b>Case Number:</b>	CM14-0046608		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	05/07/2003
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	03/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2014

### 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 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 65-year-old male with a reported date of injury on 05/07/2003. The mechanism of injury was not submitted within the medical records. His diagnosis was noted to include lumbago. The progress note dated 02/21/2014 revealed the injured worker complained of back pain. He reported it was located diffusely at the lumbosacral spine and described as aching and it was incapacitating. The injured worker also presented with left shoulder pain and bilateral hand pain. The physical examination revealed the upper extremity shoulder glenohumeral joint had tenderness and pain with resisted abduction and pain with resisted biceps flexion. The lumbar spine had noted tenderness and pain and the provider reported the pain management was worsening due to lack of medications. The Request for Authorization form dated 03/18/2014 was for Lidoderm 5% patches #180 for 90 days with 2 refills for lower back pain and Physical Therapy twice a week for 8 weeks for lumbago. The Request for Authorization form was not for Hydrocodone/ Acetaminophen 10/325mg #540 with 2 refills for a 90 day supply for pain and the provider's rationale was not submitted within the medical records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm 5%, #180 with 2 refills for 90 day supply:** 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 Topical Analgesics Page(s): 111-112.

**Decision rationale:** The request for Lidoderm 5% #180 with 2 refills for a 90 day supply is not medically necessary. The injured worker has been utilizing Lidoderm. The injured worker complains of pain at the lumbosacral spine, left shoulder and bilateral hand pain. The California Chronic Pain Medical Treatment Guidelines state "topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety." The guidelines primarily recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of any of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended; is not recommended. The guidelines recommend Lidocaine for neuropathic pain after there has been evidence of first line therapy (Tricyclic or SNRI Antidepressants or an AED, such as Gabapentin or Lyrica). Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulation of Lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. There is a lack of documentation regarding objective evidence or a diagnosis of localized peripheral pain that has failed to respond to first line therapies in regards to Gabapentin, Tricyclic, or SNRI Antidepressants. Additionally, the request failed to provide the frequency at which this medication is to be utilized; therefore, the request is not medically necessary.

**Hydrocodone-Acetaminophen 10/325 mg #540 with 2 refills for a 90 day supply:** 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 Opioids, On-going Management Page(s): 78.

**Decision rationale:** The request for Hydrocodone/Acetaminophen 10/325mg #540 with 2 refills for a 90 day supply is not medically necessary. The injured worker has been utilizing this medication since at least 10/2013. According to the California Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state "that the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors," should be addressed. There is a lack of evidence of decreased pain on a numerical scale with medications, improved functional status, side effects, and without details regarding urine drug testing to verify appropriate medication use in the absence of aberrant behavior; therefore, the ongoing use of opioid medications is not supported by the guidelines. Additionally, the request failed to provide the frequency at which this medication is to be utilized. As such, the request is not medically necessary.

**Physical Therapy, 2 x 8 for lumbago:** 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 Physical Medicine Page(s): 98-99.

**Decision rationale:** The request for physical therapy, 2 x 8 visits for the lumbago is not medically necessary. The California Chronic Pain Medical Treatment Guidelines recommend active therapy based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The guidelines recommend for myalgia and myositis 9 to 10 visits over 8 weeks. There is a lack of documentation regarding current measureable objective functional deficits and quantifiable objective functional improvements from previous physical therapy sessions; therefore, the request for physical therapy is not medically necessary. Additionally, the request for 16 sessions of physical therapy exceeds guidelines recommendations.