

<b>Case Number:</b>	CM14-0090314		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	02/14/2007
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	06/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2014

### 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 Arizona. 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 34 year old male with a date of injury on 2/14/2007. Diagnosis is of complex regional pain syndrome of the left arm. Subjective complaints are of continued pain along the left side of the neck and entire left upper extremity. Physical exam shows patient is alert, and ambulates with a one point cane. Medications include Lidoderm, Protonix, Elavil, Lyrica, and Celebrex. Records indicate that a trial of Lidoderm allowed for improved function and more activities, and that patient had previously tried gabapentin and tri-cyclic and SNRI anti-depressants. Office notes state that the request for gabapentin is to replace Gralise as it is more cost effective. Utilization review appeal indicates that the patient has specifically previously tried and failed gabapentin.

### 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) #90 with 4 refills:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Criteria for use of Lidoderm patches.

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

**Decision rationale:** CA MTUS states that topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. Lidocaine in the form of lidoderm is only FDA approved for post-herpetic neuralgia. For this patient, records indicate that the patient has utilized first-line therapy and that lidocaine patches were efficacious for his neuropathic pain. Therefore, the request for lidocaine patches is consistent with guideline recommendations, and the medical necessity is established.

**Gabapentin 300mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines AEDs Page(s): 16-22.

**Decision rationale:** CA MTUS indicates that gabapentin is an anti-seizure medication and is recommended for neuropathic pain. CA MTUS also adds that following initiation of treatment there should be documentation of at least 30% pain relief and functional improvement. The continued use of an AED for neuropathic pain depends on these improved outcomes. While CA MTUS guidelines indicate that gabapentin is recommended for chronic regional pain syndrome, documentation shows that the patient has already tried and failed this medication. Therefore, the medical necessity for gabapentin is not established.