

<b>Case Number:</b>	CM14-0189720		
<b>Date Assigned:</b>	11/20/2014	<b>Date of Injury:</b>	02/17/2000
<b>Decision Date:</b>	01/08/2015	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/13/2014

### 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, has a subspecialty in Interventional Spine 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 patient is a 59-year-old female with date of injury of 02/17/2000. The listed diagnoses from 09/05/2014 are: 1. Post laminectomy syndrome of the cervical region; 2. Cervicalgia; 3. Headache; 4. Lumbago; 5. Degeneration of the lumbar or lumbosacral intervertebral disc; 6. Lumbosacral spondylosis with myelopathy; 7. Displacement of the lumbar intervertebral disc without myelopathy; 8. Pain in the joint involving the lower leg; 9. Pelvic region pain. According to this report, the patient complains of head, bilateral arms, bilateral legs, neck, bilateral shoulders, bilateral buttocks, thoracic spine, left elbow, bilateral hips, chest wall, bilateral hands, bilateral knees, bilateral low back, right ankle/foot, and groin pain. In the last month with medication, her least pain is 3/10, average pain is 4/10, worst pain is a 5/10. Without medications her lowest pain is 4/10, average pain 6/10, and highest pain 7/10. Examination shows severely restricted range of motion in the neck. Tender hypertonic bilateral mid trapezius muscles. No other findings were noted on this report. The documents include progress reports from 03/19/2014 to 10/03/2014. The utilization review denied request on 10/24/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren 1%:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

**Decision rationale:** This patient presents with multiple body part complaints. The treating physician is requesting Voltaren Gel 1%. The MTUS Guidelines page 111 on topical analgesics states that it is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS also states that Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment of osteoarthritis. It is, however, indicated for short term use, between 4-12 weeks. It is indicated for patient with osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. The records do not show a history of Voltaren use. The MTUS Guidelines are specific that topical NSAIDs are, "Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder." In this case, the patient has chronic arthritic bilateral knee and right ankle/foot pain. MTUS does support the usage of Voltaren gel for treatment of peripheral joint arthritic pain. The request is medically necessary.

**Lidoderm 5% patch #1:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch); Lidocaine Page(s): 56-57; 112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, Lidoderm® (lidocaine patch)

**Decision rationale:** This patient presents with multiple body part complaints. The treating physician is requesting Lidoderm 5% Patch Quantity One. MTUS guidelines page 57 states, "topical lidocaine 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)." MTUS Page 112 also states, "Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain." When reading ODG guidelines, it specifies that lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. The records do not show a history of Lidoderm patch use. The treating physician does not discuss the rationale behind the request. Given that the patient does not present with localized neuropathic peripheral pain, the request is not medically necessary.