

<b>Case Number:</b>	CM14-0192475		
<b>Date Assigned:</b>	11/26/2014	<b>Date of Injury:</b>	05/22/2013
<b>Decision Date:</b>	01/12/2015	<b>UR Denial Date:</b>	10/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2014

### 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 Occupational Medicine 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:

Injured worker is a male with date of injury 5/22/2013. Per pain management consultation dated 10/16/2014, the injured worker complains of pain around the left hand radiating into the left arm. He has been diagnosed with bilateral carpal tunnel syndrome and he has had bilateral carpal tunnel release surgeries. He returned to work in April 2014 but then developed significant pain around the left hand. X-rays revealed arthritis in the left hand. He had surgery on the left hand in July 2014 and notes he currently has thumb and hand pain that radiates to the left forearm. Pain is worse in the morning, and he has difficulty sleeping at night. He is currently in physical therapy. He notes some tingling around the left thumb and reports a history of trigger finger. He has problems opening boxes, opening jars, and doing gripping and grasping activities with his left hand. Examination of the upper extremities noted no signs of dystrophy, atrophy, or trophic changes. Mobility appeared to be intact at the left wrist, thumb and fingers. Skin was symmetrically warm to touch in both hands. There was no allodynia. There was localized tenderness at the base of the left thumb. There was positive Tinel's sign at the base of the left thumb with tingling radiating up to the thumb. Jamar grip strength in the right hand was 85 and left hand 42. Diagnoses include 1) arthritis of hand 2) neuralgia 3) carpal tunnel syndrome.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One tube of Lidocaine 4% topical cream 1.5 grams:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics section Page(s): 111-113.

**Decision rationale:** Topical lidocaine is used primarily for neuropathic pain when trials of antidepressant and anticonvulsants have failed. Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritics. The injured worker may be suffering from neuropathic pain, but it does not appear that he has failed trials of antidepressants and anticonvulsants. He is also being prescribed gabapentin along with the topical lidocaine. Lidocaine cream is not a formulation recommended for treatment of neuropathic pain. The request for One tube of Lidocaine 4% topical cream 1.5 grams is determined to not be medically necessary.

**Norco 10/325mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section, Weaning of Medications section Page(s): 74-95, 124.

**Decision rationale:** The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The medical reports indicate that there was concern of chronic use of Norco by the treating physicians. The current prescription does not appear to be a reduction from previous prescriptions. Efficacy of Norco use is not addressed in terms of objective functional improvement, pain reduction, or improvement in quality of life. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The request for Norco 10/325mg #90 is determined to not be medically necessary.