

<b>Case Number:</b>	CM14-0193210		
<b>Date Assigned:</b>	12/01/2014	<b>Date of Injury:</b>	08/19/2007
<b>Decision Date:</b>	01/13/2015	<b>UR Denial Date:</b>	10/22/2014
<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 Internal Medicine, and is licensed to practice in New York. 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 claimant is a 56 year old female who sustained an industrial injury on 08/19/2008. The mechanism of injury was not provided for review. Her diagnoses include bilateral carpal tunnel syndrome, status post bilateral carpal tunnel release, and right shoulder rotator cuff syndrome. He continues to complain of 5/10 right shoulder pain and bilateral wrist pain. On physical exam there is pain with range of motion of the right shoulder. There is pain with range of motion of both wrists with numbness in the median nerve distribution of both hands. Treatment in addition to surgery has consisted of medical therapy including opiates and nonsteroidal anti-inflammatory medications, topical medications, and wrist splints. The treating provider has requested Diclofenac/Lidocaine cream 180gm.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Diclofenac/Lidocaine Cream 180gm:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain

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

**Decision rationale:** There is no documentation provided necessitating use of the requested topical medications. Per California MTUS Guidelines topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists,  $\gamma$  agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating the use of Lidocaine patches. Per California MTUS 2009 Guidelines Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants or an anticonvulsant medication such as gabapentin or Lyrica). The medication is only FDA approved for post-herpetic neuralgia. There is no documentation of intolerance to other previous treatments and in fact the claimant is maintained on oral non-steroidal anti-inflammatory therapy. There is no indication for both oral and topical anti-inflammatory therapy for the treatment of chronic musculoskeletal pain. Medical necessity for the requested topical medications has not been established. The requested treatments are not medically necessary.