

<b>Case Number:</b>	CM15-0004568		
<b>Date Assigned:</b>	01/12/2015	<b>Date of Injury:</b>	01/25/2002
<b>Decision Date:</b>	03/26/2015	<b>UR Denial Date:</b>	12/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 (IW) is a 51 year old female, who sustained a cumulative industrial injury from January 25, 2002 through September 13, 2003. She has reported neck pain, mainly on the right, radiating to the shoulder, elbow, forearm and thumb with associated numbness and tingling, right hand, thumb and wrist pain, left wrist and hand pain both with associated tingling and numbness, insomnia secondary to pain and increased depression due to pain and was diagnosed with overuse syndrome of both upper extremities, right greater than left, tendinitis, status post bilateral carpal tunnel surgery, neuropathic pain and radiculopathies. Treatment to date has included radiographic imaging, diagnostic studies, multiple surgical interventions, physical therapy, pain medications and treatment modalities. Currently, the IW complains of neck pain, mainly on the right, radiating to the shoulder, elbow, forearm and thumb with associated numbness and tingling, right hand, thumb and wrist pain, left wrist and hand pain both with associated tingling and numbness, insomnia secondary to pain and increased depression due to pain. The injured worker reported cumulative trauma from 2002 through 2003. She reported pain as previously described in spite of surgical procedures and conservative therapies. On October 14, 2014, evaluation revealed continued pain as described. The request was made to renew and adjust medications. On December 5, 2014, Utilization Review non-certified a request for Lidoderm patches 5%, noting the MTUS, ACOEM Guidelines, (or ODG) was cited. On January 5, 2015, the injured worker submitted an application for IMR for review of Lidoderm patches 5%.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm patches 5% 10cm x 15cm size on for 12 hours and off for 12 hours:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical lidocaine Page(s): 56-57, 111-113. Decision based on Non-MTUS Citation Official disability guidelines, Pain chapter, Lidoderm patches

**Decision rationale:** This patient presents with neck, right hand/thumb/wrist, and left wrist/hand pain. The treater is requesting LIDODERM PATCHES 5% 10 CM X 15 CM SIZE ON FOR 12 HOURS AND OFF FOR 12 HOURS. The RFA dated 10/22/2014 notes, "see report page 5 to 6 of 10/15/2014 report." The patient's date of injury is from 01/25/2002 and her current work status is permanent and stationary. The 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 show that the patient was prescribed Lidoderm patches prior to 10/14/2014. The report from 10/14/2014 shows medication efficacy stating, "This has been helpful." The patient has a diagnosis of left carpal tunnel syndrome, neuropathic pain syndrome and regional pain syndrome. While the continued use of Lidoderm patches may be appropriate for this patient, the quantity requested was not specified. In this case, the request for an unlimited number of Lidoderm patches is not supported by the guidelines. The request IS NOT medically necessary.

**Intermezzo 1.75mg qhs #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute, ODG Treatment in Workers Compensation, Pain Chapter (Updated 11/21/14)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Mental Illness and Stress Chapter on Zolpidem

**Decision rationale:** This patient presents with neck, right hand/thumb/wrist, and left wrist/hand pain. The treater is requesting INTERMEZZO 1.75 MG Q HS QUANTITY 30. The RFA dated 10/22/2014 shows "see report page 5 to 6 of 10/15/2014 report." The patient's date of injury is from 01/25/2002 and her current work status is permanent and stationary. The MTUS and ACOEM Guidelines are silent with regards to this request. However, ODG Guidelines under the

Mental Illness and Stress Chapter on Zolpidem states Zolpidem is indicated for the short-term treatment of insomnia with difficulty of sleep onset 7-10 days. Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien CR to be effective for up to 24 weeks in adults. The records show that the patient was prescribed intermezzo prior to 10/14/2014. In this case, the guidelines do not support the long-term use of Zolpidem. The request IS NOT medically necessary.

**Voltaren Gel 1% 100gm 2 gm to 4gm applied to affected areas:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 71. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter updated 11/21/14 Diclofenac

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

**Decision rationale:** This patient presents with neck, right hand/thumb/wrist, and left wrist/hand pain. The treater is requesting VOLTAREN GEL 1% 100 G 2GM TO 4GM APPLY TO AFFECTED AREAS. The RFA dated 10/22/2014 shows "see report page 5 to 6 of 10/15/2014 report." The patient's date of injury is from 01/25/2002 and her current work status is permanent and stationary. 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 show that the patient was prescribed Voltaren gel prior to 10/14/2014. None of the reports discuss medication efficacy as it relates to the use of Voltaren gel. The request IS NOT medically necessary.

**Omeprazole 20mg 1-2 daily:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms, and cardiovascular risks Page(s): 69.

**Decision rationale:** This patient presents with neck, right hand/thumb/wrist, and left wrist/hand pain. The treater is requesting OMEPRAZOLE 20 MG 1 TO 2 DAILY. The RFA dated 10/22/2014 shows "see report page 5 to 6 of 10/15/2014 report." The patient's date of injury is from 01/25/2002 and her current work status is permanent and stationary. The MTUS Guidelines page 68 and 69 on NSAIDs, GI symptoms, and cardiovascular risks states, Determine if the patient is at risk for gastrointestinal events: -1- age > 65 years; -2- history of peptic ulcer, GI bleeding or perforation; -3- concurrent use of ASA, corticosteroids, and/or an anticoagulant; or -

4- high dose/multiple NSAID -e.g., NSAID + low-dose ASA-. Recent studies tend to show that H. Pylori does not act synergistically with NSAIDS to develop gastroduodenal lesions. MTUS also states, Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI. The records show that the patient was prescribed omeprazole prior to 10/14/2014. It appears that the treater is requesting Omeprazole in conjunction with the patient's NSAID regimen. In this case, the guidelines do not recommend the routine use of PPI's without documentation of gastrointestinal events. The request IS NOT medically necessary.