

<b>Case Number:</b>	CM15-0102034		
<b>Date Assigned:</b>	07/16/2015	<b>Date of Injury:</b>	10/11/2012
<b>Decision Date:</b>	08/11/2015	<b>UR Denial Date:</b>	05/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 is a 53 year old male, who sustained an industrial injury on October 11, 2012. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having ulnar neuropathy at the left wrist and elbow, median nerve compression at the wrist from fracture, lumbar radiculopathy, left acromioclavicular sprain, left sprain of the elbow, lumbar sprain, cervical sprain, superior labrum anterior and posterior tear of the shoulder, and superficial nerve damage of left elbow. Treatment and diagnostic studies to date has included home exercise program, medication regimen, computed tomography of the upper extremity, status post lumbar epidural steroid injection, acupuncture, magnetic resonance imaging of the left knee, magnetic resonance imaging of the lumbar spine, and magnetic resonance imaging of the cervical spine. In a progress note dated April 6, 2015 the treating physician reports complaints of pain to the neck, low back, left shoulder, left wrist, and left elbow. Examination reveals slight tenderness to the left elbow and forearm, decreased range of motion to the left elbow, decreased range of motion to the left wrist, decreased sensation over the left lumbar four to five dermatome, tenderness to the lumbar paraspinal muscles with the left greater than the right, increased pain with lumbar range of motion, tenderness to the left knee medial joint line and patella, and left knee crepitus. The injured worker's medication regimen included Norco, Flexeril, Lidoderm Patch, Metformin, and Glimepiride, but the documentation provided did not indicate the injured worker's pain level as rated on a pain scale prior to use of his medication regimen and after use of his medication regimen to indicate the effects with the use of the injured worker's medication regimen. The

treating physician indicated that the injured worker is able to perform activities of daily living with use of his medication regimen, is able to care for his children with the use of his medication regimen, and has improvement of sleep with his medication regimen. The treating physician noted that the injured worker experienced over 50 percent of pain relief secondary to prior lumbar epidural steroid injection performed on 01/06/2015. The injured worker was noted to have no radicular pain and was able to walk a mile twice a day due to the prior epidural steroid injection. The treating physician requested bilateral lumbar five transforaminal epidural steroid injections under fluoroscopic guidance and conscious sedation with the treating physician noting over a 50 percent reduction of pain with relief to the low back and lower extremities that has lasted for three months. The treating physician noted that the pain has returned and the injured worker would benefit from another injection. The treating physician also requested Lidoderm 5% Patch for neuropathic pain and sensitivity along with noting that the injured worker tries to take few oral medications due to his diabetes, and also notes that this medication is a current medication of the injured worker.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Bilateral L5 Transforaminal epidural steroid injection (TFESI) Under Fluoroscopic Guidance and Conscious Sedation: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

**Decision rationale:** The California chronic pain medical treatment guidelines section on epidural steroid injections (ESI) states: Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. According to guidelines, 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007). 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. Previous ESI did produce a 50 percent reduction in

pain lasting 3 months but there was no documented concomitant decrease in medication usage. Therefore criteria for repeat ESI have not been met and the request is not medically necessary.

**Lidoderm 5 Percent Patch:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical lidocaine Page(s): s 111-112.

**Decision rationale:** The California chronic pain medical treatment guidelines section on topical lidocaine states: Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica). 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. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended (Argoff, 2006) (Dworkin, 2007) (Khaliq-Cochrane, 2007) (Knotkova, 2007) (Lexi-Comp, 2008). Non-neuropathic pain: Not recommended. There is only one trial that tested 4 percent lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo (Scudds, 1995). This medication is recommended for localized peripheral pain. The patient has no documented failure of all first line agents indicated for the treatment of neuropathic pain as outlined above. Therefore criteria as set forth by the California MTUS as outlined above have not been met and the request is not medically necessary.