

<b>Case Number:</b>	CM15-0108350		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	09/02/2005
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### 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: Emergency Medicine

### 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 49 year old male who sustained an industrial injury on 09/02/2005. Mechanism of injury occurred while operating a standup lift. Diagnoses include lumbar disc degeneration, chronic pain, failed lumbar back surgery syndrome, lumbar radiculopathy, and status post fusion of the lumbar spine. Treatment to date has included diagnostic studies, medications, home exercise program, and acupuncture. There is unofficial documentation that on 11/01/2013 a lumbar Magnetic Resonance Imaging was done and revealed disc desiccation is noted at T11-12 and L1-2 levels, reduced intervertebral disc height is noted at T11-12 and L1-2 levels. Hardware is intact with post-surgical changes noted, L1-L2 diffuse disc protrusion, more marked par centrally, effacing the thecal sac. L1 exiting nerve roots are unremarkable. Disc measurements: neutral 3.7mm. An Electromyography and Nerve Conduction studies of the lower extremities done on 11/04/2015 were normal. A physician progress note dated 04/08/2015 documents the injured worker complains of neck pain that is accompanied by numbness intermittently in the left upper extremity to the level of the hand. He has frequent muscle spasm in the neck area. He has low back pain that radiates down the bilateral lower extremities, and into the bilateral buttocks and to bilateral feet. The pain is accompanied by numbness frequently in the bilateral lower extremities to the level of the feet and muscle weakness frequently in the left lower extremity. The pain is described as burning, electrical and stabbing. The injured worker complains of frequent muscle spasms in the lower back bilaterally and numbness in the left buttock. He has upper extremity pain and bilateral shoulder pain. He has middle back pain that travels through the upper and lower back. Pain is rated as 7-8 out of 10 on average with

medications and 10 out of 10 on average without medications. The injured worker reports gastroesophageal reflux disease related, medications associated gastrointestinal upset. On examination there is spasm and tenderness to the cervical and lumbar spine. There is limited range of motion of the lumbar spine. The treatment plan includes continuing with his home exercise program, a urine drug screen was obtained, Flexeril, Gabapentin, Hydrocodone/APAP, and EnoRx-Ibuprofen 10% have been reordered, and Ketoprofen has been discontinued. Treatment requested is for Lidocaine gel HCL 2% #60.

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

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

**Lidocaine gel HCL 2% #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 63-64, 78, 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57.

**Decision rationale:** As per MTUS chronic pain guidelines, the only topical lidocaine approved for pain is lidoderm. Other topical forms are for mild pruritus or rectal irritation. Lidoderm/Lidocaine patch is only approved for peripheral neuropathic pain, specifically post-herpetic neuralgia. There is poor evidence to support its use in other neuropathic pain such as patient's diagnosis of radiculopathy. It may be considered after failure of 1st line treatment. Patient does not meet any indication for use of topical lidocaine and requested lidocaine is likely an off label of other forms of lidocaine or a non-FDA approved compounded formulation. Lidocaine gel is not medically necessary.