

<b>Case Number:</b>	CM15-0018698		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	09/07/1999
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	01/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/02/2015

### 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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 47-year-old female who reported an injury on 09/07/1999. The mechanism of injury was not provided. The diagnosis included lumbar disc bulge and radiculitis, headaches, status post cervical C5-7 fusion, and bilateral shoulders sprain/strain. The documentation of 12/17/2014 revealed the injured worker had subjective complaints of pain in the suboccipital head described as a pulling sensation. The injured worker had pain in the neck and low back. The injured worker was noted to have difficulty falling asleep due to pain. The injured worker indicated she had been utilizing a lumbar support and it was temporarily helpful. The injured worker's medications included ibuprofen 500 mg 1 tablet 3 times a day, Soma for muscle spasms 350 mg #60, and Norco 10/325 mg for pain. The physical examination revealed the injured worker had decreased range of motion of the cervical spine limited by pain. The injured worker had a positive seated straight leg raise on the right. The injured worker had moderate paraspinal tenderness bilaterally at the level of L4-S1. The treatment plan included: an H-wave unit; a lumbar spine and cervical epidural steroid injection; topical medications including a combination of lidocaine, gabapentin, Ketoprofen, and a LidAll patch for pain with 3 refills; and the medication Norco 10/325. There was no Request for Authorization submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #120 1 Tab QID:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain; ongoing management Page(s): 60; 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend opioids for the treatment of chronic pain. There should be documentation of objective functional improvement and an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to indicate the injured worker had objective functional improvement and objective decrease in pain, as well as documentation the injured worker was being monitored for aberrant drug behavior and side effects. Given the above, the request for Norco 10/325mg #120 1 Tab QID is not medically necessary.

**Lidall Patch (Lidocaine) for Pain 1 Patch with 3 Refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain, Topical Analgesic; Lidocaine Page(s): 111; 28; 112.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines indicate that topical lidocaine (Lidoderm) 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). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant nonadherence to guideline recommendations. There was a lack of documentation indicating the injured worker had tried and failed antidepressants and anticonvulsants. There was a lack of documentation indicating the necessity for 3 refills without re-evaluation. The request as submitted failed to indicate the frequency and the body part to be treated with the patch. Given the above, the request for Lidall Patch (Lidocaine) for Pain 1 Patch with 3 Refills is not medically necessary. Additionally, there was a lack of documentation indicating a necessity for both a patch and a transdermal including lidocaine.

**Lidocaine 6%, Gabapentin 10%, Ketoprofen 10% 120ml 2-3X A Day with 3 Refills:**  
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), Pain, LidoDerm (lidocaine patch).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics; Ketoprofen, Lidocaine; Gabapentin Page(s): 111; 112; 113.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen is not currently FDA approved for a topical application Gabapentin is not recommended. There is no peer-reviewed literature to support use. Other anti-epilepsy drugs: There is no evidence for use of any other anti-epilepsy drug as a topical product. The guidelines indicate that topical lidocaine (Lidoderm) 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). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide documentation the injured worker had a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation indicating a necessity for both a patch and a transdermal application of lidocaine. There was a lack of documentation indicating a necessity for 3 refills without re-evaluation. The request as submitted failed to indicate the body part to be treated. Given the above, the request for Lidocaine 6%, Gabapentin 10%, Ketoprofen 10% 120ml 2-3X A Day with 3 Refills is not medically necessary.