

<b>Case Number:</b>	CM15-0145381		
<b>Date Assigned:</b>	08/06/2015	<b>Date of Injury:</b>	08/19/1998
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	07/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/27/2015

### 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: 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 is a 57 year old female, who sustained an industrial injury on August 19, 1998. The injured worker was diagnosed as having cervical spondylosis, cervical facet joint pain, shoulder impingement, carpal tunnel, De Quervain's tenosynovitis, failed back surgery syndrome, spinal cord stimulator implant, lumbar radiculitis and knee arthropathy. Treatment to date has included chiropractic treatment, multiple surgeries including lumbar, left arm and shoulder surgery, spinal cord stimulator and pain management therapy. A pain management consult note dated July 2, 2015 provides the injured worker complains of headaches and neck pain radiating to the upper extremities, shoulder pain, wrist pain low back pain radiating to the lower extremities and knee pain. She rates her pain 10 out of 10. She reports falling 1 or 2 times a week and decreased strength. She has sleep disturbance and anxiety with depression due to pain. Physical exam notes decreased range of motion (ROM) of the neck and lumbar area. There is positive McMurray's and Kemp's test. There is marked disability with limited mobility with the use of a walker. The plan includes oral and topical medication, toilet supports, hospital bed and scooter.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**30 gms of Cyclobenzaprine 10% and Lidocaine 2%: Upheld**

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

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

**Decision rationale:** This patient presents with neck, shoulder/upper extremities, low back, bilateral knees severe chronic pains. The request is for 30 gms of Cyclobenzaprine 10% and Lidocaine 2%. The patient is s/p 3 level fusion of L-spine, had spinal cord stimulator implant. MRI and CT studies showed multilevel degenerative changes with EDX studies showing bilateral carpal tunnel syndrome and chronic L5 radiculopathy on the left. Motor strength is 5/5 in upper and lower extremities, with limited mobility on walker. Report 12/4/14 states "She does not wish to take oral medications at this time secondary to gastrointestinal upset. I recommended that she use topical medications for pain control at this time." MTUS p111, Topical Analgesics section, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." "Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product." None of the reports indicate how this topical is being used, for which body parts, and with what effectiveness. More importantly, there is lack of support from MTUS for this combination of medication. Flexeril is not supported for topical formulation. The request IS NOT medically necessary.

**30 gms of Flurbiprofen 20% and Lidocaine 2%:** Upheld

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

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

**Decision rationale:** This patient presents with neck, shoulder/upper extremities, low back, bilateral knees severe chronic pains. The request is for 30 gms of Flurbiprofen 20% and Lidocaine 2%. The patient is s/p 3 level fusion of L-spine, had spinal cord stimulator implant. MRI and CT studies showed multilevel degenerative changes with EDX studies showing bilateral carpal tunnel syndrome and chronic L5 radiculopathy on the left. Motor strength is 5/5 in upper and lower extremities, with limited mobility on walker. Report 12/4/14 states "She does not wish to take oral medications at this time secondary to gastrointestinal upset. I recommended that she use topical medications for pain control at this time." MTUS p111, Topical Analgesics section, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." 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 anti-depressants 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. None of the reports indicate how this topical is being used, for which body parts, and with what effectiveness. More importantly, there is lack of support from MTUS for this combination of medication. Topical Lidocaine is only supported in patch formulation and not in lotion/cream/gel. The request IS NOT medically necessary.

**30 gms of Gabapentin 10% and Amitriptyline 5% and Capsaicin: Upheld**

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

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

**Decision rationale:** This patient presents with neck, shoulder/upper extremities, low back, bilateral knees severe chronic pains. The request is for 30 gms of Gabapentin 10% and Amitriptyline 5% and Capsaicin. The patient is s/p 3 level fusion of L-spine, had spinal cord stimulator implant. MRI and CT studies showed multilevel degenerative changes with EDX studies showing bilateral carpal tunnel syndrome and chronic L5 radiculopathy on the left. Motor strength is 5/5 in upper and lower extremities, with limited mobility on walker. Report 12/4/14 states "She does not wish to take oral medications at this time secondary to gastrointestinal upset. I recommended that she use topical medications for pain control at this time." MTUS p111, Topical Analgesics section, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Gabapentin: Not recommended. There is no peer-reviewed literature to support use. None of the reports indicate how this topical is being used, for which body parts, and with what effectiveness. More importantly, there is lack of support from MTUS for this combination of medication. Topical Gabapentin is not supported by MTUS for topical formulation. The request IS NOT medically necessary.

**1 prescription for Terocin patches 1.3% #30: Upheld**

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

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

**Decision rationale:** This patient presents with neck, shoulder/upper extremities, low back, bilateral knees severe chronic pains. The request is for 1 prescription for Terocin patches 1.3% #30. The patient is s/p 3 level fusion of L-spine, had spinal cord stimulator implant. MRI and CT studies showed multilevel degenerative changes with EDX studies showing bilateral carpal tunnel syndrome and chronic L5 radiculopathy on the left. Motor strength is 5/5 in upper and lower extremities, with limited mobility on walker. Report 12/4/14 states "She does not wish to take oral medications at this time secondary to gastrointestinal upset. I recommended that she use topical medications for pain control at this time." MTUS p112, 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 anti-depressants 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. This patient presents with wide-spread pain and for some of the body parts, the use of Lidocaine patch may be indicated. However, none of

the reports discuss this medication specifically, in terms of how it is used, for which body part and with what effectiveness. It is indicated for peripheral, localized neuropathic pain and the treater does not document where it is used. The request IS NOT medically necessary.

**Hospital Bed:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.aetna.com/cpb/medical/data/500\\_599/0543.html](http://www.aetna.com/cpb/medical/data/500_599/0543.html).

**Decision rationale:** This patient presents with neck, shoulder/upper extremities, low back, bilateral knees severe chronic pains. The request is for 1 prescription for Terocin patches 1.3% #30. The patient is s/p 3 level fusion of L-spine, had spinal cord stimulator implant. MRI and CT studies showed multilevel degenerative changes with EDX studies showing bilateral carpal tunnel syndrome and chronic L5 radiculopathy on the left. Motor strength is 5/5 in upper and lower extremities, with limited mobility on walker. 7/2/15 report indicates "patient is having significant difficulty in daily mobility; she is falling. Recommend lightweight scooter as indicated by medical supply evaluation. This has been non-certified by IMR." Reports multiple falls due to loss of balance and loss of sensation in the left leg, and home health evaluation is recommended due to her inability to safely perform ADL's. "I also recommend upper body supports when toileting, and a hospital bed. This has been non-certified by IMR." MTUS, ACOEM and ODG are silent regarding hospital beds.

[www.aetna.com/cpb/medical/data/500\\_599/0543.html](http://www.aetna.com/cpb/medical/data/500_599/0543.html), AETNA guideline has the following: Aetna considers hospital beds medically necessary DME for members who meet any of the following criteria: The member's condition requires positioning of the body; e.g., to alleviate pain, promote good body alignment, prevent contractures, avoid respiratory infections, in ways not feasible in an ordinary bed; or The member requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been considered; or The member's condition requires special attachments (e.g., traction equipment) that cannot be fixed and used on an ordinary bed. A hospital bed is one with manual head and leg elevation adjustments. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed. In this case, the patient does not require any positioning of the body, the head does not need to be lifted, and no special attachment requirement is present. The request IS NOT medically necessary.

**1 Mobility scooter:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99.

**Decision rationale:** This patient presents with neck, shoulder/upper extremities, low back, bilateral knees severe chronic pains. The request is for 1 prescription for Terocin patches 1.3% #30. The patient is s/p 3 level fusion of L-spine, had spinal cord stimulator implant. MRI and CT studies showed multilevel degenerative changes with EDX studies showing bilateral carpal tunnel syndrome and chronic L5 radiculopathy on the left. Motor strength is 5/5 in upper and

lower extremities, with limited mobility on walker. 7/2/15 report indicates "patient is having significant difficulty in daily mobility; she is falling. Recommend lightweight scooter as indicated by medical supply evaluation. This has been non-certified by IMR." Reports multiple falls due to loss of balance and loss of sensation in the left leg, and home health evaluation is recommended due to her inability to safely perform ADL's. "I also recommend upper body supports when toileting, and a hospital bed. This has been non-certified by IMR." MTUS p99, Power Mobility Devices: Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. In this case, the reports indicate 5/5 motor strength in all four extremities. However, the patient is reporting frequent falls, and inability to safely perform ADL's. Although examination reports 5/5 strength, this information does not comport with what is reported in terms of function. Social mobility is an important part of daily function and with the patient being dependent on the use of walker, problems with both hands, shoulders and neck as well as chronic low back pain, the use of a scooter appear reasonable. It does not appear likely or realistic that this patient can effectively use a manual wheelchair. The request IS medically necessary.