

<b>Case Number:</b>	CM15-0187210		
<b>Date Assigned:</b>	09/29/2015	<b>Date of Injury:</b>	05/22/2015
<b>Decision Date:</b>	11/10/2015	<b>UR Denial Date:</b>	08/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2015

### 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 38 year old female, who sustained an industrial injury on 5-22-2015. The injured worker was being treated for bilateral wrist tenosynovitis. On 7-24-2015, the injured worker reported ongoing, moderately severe, constant bilateral wrist pain, which was described as dull, tingling, burning, and numbness. Associated symptoms included pain with wrist motion and restricted wrist motion. Repetitive work worsened her symptoms and rest lessened her symptoms. Her pain was rated 8 out of 10. The physical exam (7-24-2015) revealed tenderness to palpation flexor surface, restricted range of motion, and 5 out of 5 muscle strength of the bilateral wrists. There were positive Phalen's and Tinel's signs of the bilateral wrist. Treatment has included physical therapy, temporary total disability, work restrictions, day and night splints, and medications including muscle relaxant and non-steroidal anti-inflammatory. Per the treating physician (7-24-2015 report), the injured worker was to continue working with restrictions that included limited overhead work and limited lifting, pushing, and pulling over 10 pounds. In addition, must take a stretch break for 5 minutes after every 30 minutes from key board and repetitive motion. The requested treatments included Lidocaine 5% patch. On 8-25-2015, the original utilization review non-certified a request for Lidocaine 5% patch Qty: 6.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro (DOS 7/24/15) Lidocaine 5% patch Qty: 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**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% 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 does have peripheral pain in the form of wrist pain, however 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.