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| <b>Case Number:</b>   | CM15-0039477 |                              |            |
| <b>Date Assigned:</b> | 03/10/2015   | <b>Date of Injury:</b>       | 01/14/2008 |
| <b>Decision Date:</b> | 04/10/2015   | <b>UR Denial Date:</b>       | 02/04/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/03/2015 |

### 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 66-year-old female, who sustained a work/ industrial injury on 1/14/08. She has reported initial symptoms of neck and low back pain. The injured worker was diagnosed as having cervicalgia, cervical facet syndrome at C4-5, C5-6, right and left sided C7 radiculopathy, and right L5 radiculopathy. Treatments to date included Medication (Gabapentin, lidocaine 5% topical ointment), and physical therapy. Currently, the injured worker complains of neck and low back pain with diagnosis of cervicalgia, cervical facet syndrome at C4-5 and C5-6, right and left C7 radiculopathy. The pain management consultation report from 12/15/14 indicated increased neck and back pain over the past year with difficulty turning from side to side. Pain was 6-8/10. There was also tingling and burning sensations that go down the arms and into the low back area and into the legs. Exam noted positive slumps testing on the right side of the right lower limb with referred pain down the calf. Spurling's was negative on the right and left side. There was decreased sensation in the medial aspect of the palm on the right and left side. Plan was to order diagnostic testing, acupuncture sessions, begin Tizanidone and Naprosyn and continue medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Gabapentin 300mg #30 with 4 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 18-19.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy drugs Page(s): 16-18.

**Decision rationale:** The requested Gabapentin 300mg #30 with 4 refills, is not medically necessary. Chronic Pain Medical Treatment Guidelines, Anti-Epilepsy drugs, Pages 16-18, 21, note that anti-epilepsy drugs are "Recommended for neuropathic pain due to nerve damage," and "Outcome: A 'good' response to the use of AEDs has been defined as a 50% reduction in pain and a 'moderate' response as a 30% reduction." The injured worker has neck and low back pain. The treating physician has documented positive slumps testing on the right side of the right lower limb with referred pain down the calf. Spurling's was negative on the right and left side. There was decreased sensation in the medial aspect of the palm on the right and left side. The treating physician has not documented the guideline-mandated criteria of percentages of relief to establish the medical necessity for its continued use. The criteria noted above not having been met, Gabapentin 300mg #30 with 4 refills is not medically necessary.

**Lidocaine 5% ointment #1 tube with 4 refills:** Upheld

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

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

**Decision rationale:** The requested Lidocaine 5% ointment #1 tube with 4 refills, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Lidoderm, Pages 56-57, note that "Topical lidocaine 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)". It is not considered first-line therapy and only FDA approved for post-herpetic neuralgia. The injured worker has neck and low back pain. The treating physician has documented positive slumps testing on the right side of the right lower limb with referred pain down the calf. Spurling's was negative on the right and left side. There was decreased sensation in the medial aspect of the palm on the right and left side. The treating physician has not documented failed Gabapentin trials, nor the medical necessity for additional refills of Lidoderm absent documented functional improvement from an initial trial. The treating physician has not documented the guideline-mandated criteria of percentages of relief to establish the medical necessity for its continued use. The criteria noted above not having been met, Lidocaine 5% ointment #1 tube with 4 refills is not medically necessary.