

<b>Case Number:</b>	CM15-0065892		
<b>Date Assigned:</b>	04/13/2015	<b>Date of Injury:</b>	11/05/2012
<b>Decision Date:</b>	07/09/2015	<b>UR Denial Date:</b>	03/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2015

### 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 45 year old female, who sustained an industrial injury on 11/05/2012. On provider visit dated 03/04/2015 the injured worker has reported lower back pain that travels to bilateral legs, with numbness and tingling. The injured worker also reported difficulty sleeping. On examination of the lumbar spine she was noted to have a decreased range of motion, straight leg raise was positive, toe walk was positive on the right, palpation revealed moderate paraspinal and spinal tenderness, muscle guarding and spasms bilaterally. The diagnoses have included discogenic back pain, rule out herniated nucleus pulposus, lumbar spine disc protrusion and depression. Treatment to date has included laboratory studies, Toradol injections, and medication. The provider requested topical ointment for inflammation, topical medication for pain, psychotherapy, outpatient neurosurgery consultation and treatment, and Lidall patch.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Topical ointment for inflammation 240g (Lidocaine 6%, Gabapentin 20%, Ketoprofen 10%) with three (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 Topical analgesic Page(s): 111-113.

**Decision rationale:** Based on the 03/04/15 progress report provided by treating physician, the patient presents with low back pain that radiates to the bilateral legs, rated 7/10. The request is for topical ointment for inflammation 240g (Lidocaine 6%, Gabapentin 20%, Ketoprofen 10%) with three (3) refills. RFA dated 03/04/15 provided. Patient's diagnosis on 03/04/15 includes discogenic back pain, rule out herniated nucleus pulposus, lumbar spine 6-7mm disc protrusion at L4-L5, depression, incontinence of feces and other urinary incontinence. Physical examination to the lumbar spine on 03/04/15 revealed guarding, spasm and tenderness to palpation to L4-S1 bilaterally. Range of motion decreased, especially on extension 10 degrees. Positive Kemp's, Facet, and Straight Leg Raise tests bilaterally. Treatment to date has included laboratory studies, Toradol injections, epidural steroid injection 07/08/14 and medications. Patient's medications include Prilosec, Acetaminophen/Codeine, and Soma. The patient has been instructed to return to modified duty, per 03/04/15 report. Treatment reports were provided from 04/02/14 - 03/04/15. MTUS has the following regarding topical creams (p111, chronic pain section): Topical Analgesics: Non-steroidal antiinflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. MTUS further states, Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. 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. Gabapentin: Not recommended. Baclofen: Not recommended. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product. Treater is requesting this topical for inflammation. In this case, there are no discussions regarding location that will be treated, nor medication efficacy. Furthermore, MTUS page 111 states that if one of the compounded topical products is not recommended, then the entire product is not. In this case, the requested topical compound contains Lidocaine, Gabapentin and Ketoprofen, which are not supported for topical use in lotion form, per MTUS. The request does not meet guideline indications. Therefore, the request IS NOT medically necessary.

**Topical medication for joint pain 240g (Flurbiprofen 15%, Cyclobenzaprine 10%, Menthol 5%, Lidocaine 5%) with three (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 Topical Analgesics Page(s): 111-113.

**Decision rationale:** Based on the 03/04/15 progress report provided by treating physician, the patient presents with low back pain that radiates to the bilateral legs, rated 7/10. The request is for topical medication for joint pain 240g (Flurbiprofen 15%, Cyclobenzaprine 10%, Menthol 5%, Lidocaine 5%) with three (3) refills. RFA dated 03/04/15 provided. Patient's diagnosis on 03/04/15 includes discogenic back pain, rule out herniated nucleus pulposus, lumbar spine 6-7mm disc protrusion at L4-L5, depression, incontinence of feces and other urinary incontinence. Physical examination to the lumbar spine on 03/04/15 revealed guarding, spasm and tenderness to palpation to L4-S1 bilaterally. Range of motion decreased, especially on extension 10 degrees. Positive Kemp's, Facet, and Straight Leg Raise tests bilaterally. Treatment to date has included laboratory studies, Toradol injections, epidural steroid injection 07/08/14 and medications. Patient's medications include Prilosec, Acetaminophen/Codeine, and Soma. The patient has been instructed to return to modified duty, per 03/04/15 report. Treatment reports were provided from 04/02/14 - 03/04/15. MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Non-steroidal antiinflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. 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. Gabapentin: Not recommended. Baclofen: Not recommended. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product." In this case, there are no discussions regarding location that will be treated, nor medication efficacy. The patient does not present with peripheral joint arthritis/tendinitis, for which an NSAID topical would be indicated. Furthermore, MTUS page 111 states that if one of the compounded topical products is not recommended, then the entire product is not. In this case, the requested topical compound contains Lidocaine and Cyclobenzaprine, which are not supported for topical use in lotion form, per MTUS. The request does not meet guideline indications. Therefore, the request IS NOT medically necessary.

**Lidall patch with three (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 Lidoderm patches Topical analgesic Page(s): 56-57, 112. Decision based on Non-MTUS Citation Official disability guidelines Pain Chapter on Lidoderm.

**Decision rationale:** Based on the 03/04/15 progress report provided by treating physician, the patient presents with low back pain that radiates to the bilateral legs, rated 7/10. The request is for Lidall patch with three (3) refills. RFA dated 03/04/15 provided. Patient's diagnosis on 03/04/15 includes discogenic back pain, rule out herniated nucleus pulposus, lumbar spine 6-7mm disc protrusion at L4-L5, depression, incontinence of feces and other urinary incontinence. Physical examination to the lumbar spine on 03/04/15 revealed guarding, spasm and tenderness

to palpation to L4-S1 bilaterally. Range of motion decreased, especially on extension 10 degrees. Positive Kemp's, Facet, and Straight Leg Raise tests bilaterally. Treatment to date has included laboratory studies, Toradol injections, epidural steroid injection 07/08/14 and medications. Patient's medications include Prilosec, Acetaminophen/Codeine, and Soma. The patient has been instructed to return to modified duty, per 03/04/15 report. Treatment reports were provided from 04/02/14 - 03/04/15. MTUS guidelines page 57 states, "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)." MTUS page 112 also states, "Lidocaine Indication: Neuropathic pain. Recommended for localized peripheral pain." When reading ODG guidelines, Pain Chapter on Lidoderm, it specifies that Lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. Treater has not provided medical rationale for the request, nor indicated body part to be treated. There is no documentation of how Lidoderm patch is used, how often and with what efficacy in terms of pain reduction and functional improvement. MTUS page 60 requires recording of pain and function when medications are used for chronic pain. Furthermore, the patient does not present with localized, peripheral neuropathic pain, for which this medication is indicated. Lidocaine patches are not supported for low back pain condition. This request is not in accordance with guideline indications. Therefore, the request IS NOT medically necessary.

**Outpatient neurosurgery consultation and treatment:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines Chapter 7.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Independent medical examination and consultations. Ch: 7 page 127.

**Decision rationale:** Based on the 03/04/15 progress report provided by treating physician, the patient presents with low back pain that radiates to the bilateral legs, rated 7/10. The request is for outpatient neurosurgery consultation and treatment. RFA dated 03/04/15 provided. Patient's diagnosis on 03/04/15 includes discogenic back pain, rule out herniated nucleus pulposus, lumbar spine 6-7mm disc protrusion at L4-L5, depression, incontinence of feces and other urinary incontinence. Physical examination to the lumbar spine on 03/04/15 revealed guarding, spasm and tenderness to palpation to L4-S1 bilaterally. Range of motion decreased, especially on extension 10 degrees. Positive Kemp's, Facet, and Straight Leg Raise tests bilaterally. Treatment to date has included laboratory studies, Toradol injections, epidural steroid injection 07/08/14 and medications. Patient's medications include Prilosec, Acetaminophen/Codeine, and Soma. The patient has been instructed to return to modified duty, per .03/04/15 report. Treatment reports were provided from 04/02/14 - 03/04/15. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) ACOEM guidelines, chapter 7, page 127 state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation

to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. Per 03/04/15 report, treater states, "I am requesting authorization Extension to address Neurosurgery Consult; Expired November 28/ 2015." Treater has not provided medical rationale for the request. The ACOEM Guidelines support the referral of patients to other specialists if a diagnosis is uncertain or extremely complex, or when the plan or course of care may benefit from additional expertise. The patient has been suffering from chronic low back radiating to the bilateral legs, and extension of neurosurgery consult would appear reasonable and indicated by guidelines. However, treater is requesting for both a consultation and possible treatment. Treatment can only be determined after the consultation takes place. While the consultation may be necessary, the request is also for "treatment", which is not defined. Therefore, the request IS NOT medically.

**Psychotherapy (no frequency noted): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Independent medical examination and consultations. Ch: 7 page 127 Official disability guidelines Mental Illness & Stress Chapter under Cognitive therapy for depression.

**Decision rationale:** Based on the 03/04/15 progress report provided by treating physician, the patient presents with low back pain that radiates to the bilateral legs, rated 7/10. The request is for psychotherapy (no frequency noted). RFA dated 03/04/15 provided. Patient's diagnosis on 03/04/15 includes discogenic back pain, rule out herniated nucleus pulposus, lumbar spine 6-7mm disc protrusion at L4-L5, depression, incontinence of feces and other urinary incontinence. Physical examination to the lumbar spine on 03/04/15 revealed guarding, spasm and tenderness to palpation to L4-S1 bilaterally. Range of motion decreased, especially on extension 10 degrees. Positive Kemp's, Facet, and Straight Leg Raise tests bilaterally. Treatment to date has included laboratory studies, Toradol injections, epidural steroid injection 07/08/14 and medications. Patient's medications include Prilosec, Acetaminophen/Codeine, and Soma. The patient has been instructed to return to modified duty, per 03/04/15 report. Treatment reports were provided from 04/02/14 - 03/04/15. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) ACOEM guidelines, chapter 7, page 127 state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. ODG-TWC, Mental Illness & Stress Chapter under Cognitive therapy for depression states: "ODG Psychotherapy Guidelines: Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made. (The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.); in cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made." Per 03/04/15 report, treater

states "the patient was extensively evaluated psychologically for continued psychosis and depression. She continues to receive treatment and change in her medication for her anxiety and depression." The patient has a diagnosis of depression and anxiety, for which ACOEM would allow for specialist referrals. However, treater has not provided a precise treatment history, nor discussed symptom improvement due to therapy. Given lack of documentation, the request is not in accordance with guidelines. Furthermore, the request is open ended without a specified duration for the treatment. Therefore, the request IS NOT medically necessary.