

<b>Case Number:</b>	CM14-0046955		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	03/07/2010
<b>Decision Date:</b>	08/06/2014	<b>UR Denial Date:</b>	04/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 52-year-old female with a reported date of injury on 03/07/2010. The mechanism of injury was not submitted within the medical records. Her previous treatments were noted to include medications, physical therapy, epidural injections, modification of activities, and water therapy. Her diagnoses were noted to include L4-5 disc protrusion, radiculopathy/radiculitis bilaterally, adult scoliosis, and neck pain. The provider reported an MRI of the lumbar spine dated 10/22/2012 revealed evidence of an L4-5 disc protrusion right paracentrally with minimal facet arthropathy and a very small L3-4 disc bulge was noted. The provider reported an electrodiagnostic study dated 12/03/2012 demonstrated right S1 radiculopathy and deep peroneal neuropathy. The injured worker received an epidural injection on 12/05/2013 which was provided significant relief; however, the back pain was radiating down both of her legs. The physical examination to the cervical spine revealed motor strength rated 4/5 bilaterally, and decreased range of motion secondary to pain. The physical examination to the lumbar spine revealed motor strength rated 4/5 bilaterally and decreased range of motion secondary to pain. The progress note dated 03/27/2014 reported the injured worker complained of pain rated 10/10 if she does not take her pain medication. The progress note dated 05/13/2014 reported the injured worker complained of low back pain and lower extremity pain. The physical examination to the lumbar spine revealed moderate pain and spasms noted over the right more than the left L4-5 and L5-S1 segments, bilateral straight leg raise positive and motor strength was noted to be 5/5 to bilateral lower extremities. Her medications were noted to include Neurontin 60 mg at night, morphine sulfate 50 mg twice a day, Lidoderm patches. The Request for Authorization Form was not submitted within the medical records. The request is for Lidoderm patches 5% #90 with 2 refills; however the provider's rationale was not submitted

within the medical records. The request for physical therapy, 2 sessions per week for 6 weeks for the lumbar spine is to reduce pain and increase the range of motion.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Lidoderm patches 5% #90 with two refills:** Upheld

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

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

**Decision rationale:** The injured worker has been diagnosed with radiculopathy. The California Chronic Pain Medical Treatment Guidelines state that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The guidelines state Lidocaine is indicated for neuropathic pain after there has been evidence of a trial of first line therapy (tricyclic or serotonin-norepinephrine reuptake inhibitors antidepressants or an antiepilepsy drug 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. The guidelines do not recommend Lidoderm for non-neuropathic pain. There is only 1 trial that tested 4% Lidocaine for treatment of chronic muscle pain and results showed there was no superior superiority over placebo. The documentation provided has clinical findings consistent with lumbar radiculopathy such as pain and spasms over the L4-5 and L5-S1 segments and bilateral straight leg raise testing, and radiculopathy is corroborated by electrodiagnostic testing; however, she does not have decreased motor strength or decreased sensation. The injured worker did not complain of neuropathic pain. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

**Physical therapy, two sessions per week for six weeks for the lumbar spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The injured worker has a decreased range of motion to the lumbar spine. The California Chronic Pain Medical Treatment Guidelines recommend active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility,

strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist or medical provider such as verbal, visual, and/or tactile instructions. Patients are instructed and expected to continue active therapies at home with an extensive of the treatment process in order to maintain appropriate levels. Home exercise can include exercise with or without mechanical assistance or a resistance in functional activities with assistive devices. The guidelines recommend for radiculitis 8 to 10 visits over 4 weeks. There is a lack of documentation regarding current measureable objective functional deficits such as range of motion and motor strength as well as quantifiable objective functional improvements with previous physical therapy visits. There is also a lack of documentation provided with the previous number of physical therapy sessions. Additionally, the request for 12 sessions of physical therapy exceeds the guidelines recommendations. Therefore, the request is not medically necessary.