

<b>Case Number:</b>	CM13-0051334		
<b>Date Assigned:</b>	04/09/2014	<b>Date of Injury:</b>	04/06/2010
<b>Decision Date:</b>	03/26/2015	<b>UR Denial Date:</b>	10/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/14/2013

### 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 45 year old male with an industrial injury dated 04/06/2010. His diagnoses include status post multilevel lumbar fusion, bilateral lower extremity radiculopathy, medication induced gastritis, status post UTI with Pyelonephritis secondary to opiate induced urinary tension, and status post lumbar spinal cord stimulator placement. Diagnostic testing has included electrodiagnostic studies (05/25/2010) revealing L5 radiculopathy, a MRI of the lumbar spine (06/01/2010) revealing multilevel disc protrusion with facet hypertrophy and bilateral neuroforaminal narrowing, a MRI of the lumbar spine (08/30/2011) showing multilevel disc protrusion with facet hypertrophy and bilateral neuroforaminal narrowing, and lumbar discogram (12/01/2011) revealing positive findings at the L4-S1 levels. Previous treatments have included placement of a lumbar fusion (07/11/2012), spinal cord stimulator (2013), medications, physiotherapy, and conservative care. In an evaluation dated 05/22/2013 (as there were no other more recent exam findings prior to the request), the treating physician reports the injured worker's history but no subjective complaints. The objective examination revealed an antalgic slow moving gait, tenderness to palpation of the posterior lumbar musculature with increased rigidity, decrease range of motion in the lumbar spine, decreased reflexes in the lower extremities, positive straight leg raises, decreased sensation in the bilateral calves, and decreased motor strength in the right lower extremity. The treating physician is requesting oral and topical medications which were denied by the utilization review. On 10/30/2013, Utilization Review non-certified a prescription for Lidoderm patch, noting that this medication is largely experimental and has been designated orphan status by the FDA, and is primarily recommended

for diabetic neuropathy pain with non-recommendation for other types of pain. The MTUS Guidelines were cited. On 10/30/2013, Utilization Review non-certified a prescription for FexMid 7.5mg #60, noting that the injured worker had been taking this medication for an extended period of time and the non-recommendation of chronic use. The MTUS Guidelines were cited. On 10/30/2013, Utilization Review non-certified a prescription for Dendracin topical analgesic, noting that this medication is largely experimental; and primarily recommended for neuropathic pain once antidepressants and anticonvulsants have failed, and that at least one of the components is not recommended. No Guidelines were cited. On 11/14/2013, the injured worker submitted an application for IMR for review of Lidoderm patch, FexMid 7.5mg #60, and Dendracin topical analgesic.

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

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

#### **FEXMID 7.5MG QTY:60.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

**Decision rationale:** The requested FEXMID 7.5MG QTY:60.00, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Muscle Relaxants, Page 63-66, do not recommend muscle relaxants as more efficacious than NSAIDs and do not recommend use of muscle relaxants beyond the acute phase of treatment. The treating physician has documented an antalgic slow moving gait, tenderness to palpation of the posterior lumbar musculature with increased rigidity, decrease range of motion in the lumbar spine, decreased reflexes in the lower extremities, positive straight leg raises, decreased sensation in the bilateral calves, and decreased motor strength in the right lower extremity. The treating physician has not documented spasticity or hypertonicity on exam, intolerance to NSAID treatment, nor objective evidence of derived functional improvement from its previous use. The criteria noted above not having been met, FEXMID 7.5MG QTY:60.00 is not medically necessary.

#### **DENDRACIN TOPICAL ANALGESIC CREAM: 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:** The requested DENDRACIN TOPICAL ANALGESIC CREAM is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the

treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The treating physician has documented an antalgic slow moving gait, tenderness to palpation of the posterior lumbar musculature with increased rigidity, decrease range of motion in the lumbar spine, decreased reflexes in the lower extremities, positive straight leg raises, decreased sensation in the bilateral calves, and decreased motor strength in the right lower extremity. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis. The criteria noted above not having been met, DENDRACIN TOPICAL ANALGESIC CREAM is not medically necessary.

**LIDODERM PATCH:** 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 Lidoderm Page(s): 56-57.

**Decision rationale:** The requested LIDODERM PATCH, 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 treating physician has documented an antalgic slow moving gait, tenderness to palpation of the posterior lumbar musculature with increased rigidity, decrease range of motion in the lumbar spine, decreased reflexes in the lower extremities, positive straight leg raises, decreased sensation in the bilateral calves, and decreased motor strength in the right lower extremity. The treating physician has not documented failed first-line therapy or documented functional improvement from the previous use of this topical agent. The criteria noted above not having been met, LIDODERM PATCH is not medically necessary.