

<b>Case Number:</b>	CM14-0213389		
<b>Date Assigned:</b>	12/30/2014	<b>Date of Injury:</b>	04/15/2005
<b>Decision Date:</b>	02/25/2015	<b>UR Denial Date:</b>	12/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2014

### 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. 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 & Rehabn

### 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 patient is a 44-year-old male with date of injury of 04/15/2005. The listed diagnoses from 11/17/2014 are: 1. Lumbar degenerative disk disease. 2. Lumbar radiculopathy. 3. Lumbar facet arthropathy. According to this report, the patient complains of upper back, lower back, right foot, right buttock, and right thigh pain. He states that his low back pain radiates down to his right lower extremity. The pain is associated with numbness and tingling in the right leg and right foot as well as weakness in his legs. He describes the pain as sharp, shooting, electric-like and burning with muscle pain, pins and needles sensation, and skin sensitivity to light touch. Examination shows range of motion is restricted in the lumbar spine. Lumbar facet loading is positive on the right side. Tenderness was noted over the right gluteus maximus. Motor strength of EHL is 4/5 on the right and 5/5 on the left. Light touch sensation is decreased over the lateral foot, lateral calf, anterior thigh, and lateral thigh on the right side. Deep tendon reflexes are 2/4 on both sides. Treatment reports from 05/10/2013 to 11/17/2014 were provided for review. The utilization review denied the request on 12/06/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm Patch 5%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine; MTUS Lidocaine Page(s): 57; 112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Lidoderm® (lidocaine patch)

**Decision rationale:** This patient presents with upper back, low back, right foot, right buttock, and right thigh pain. The treater is requesting Lidoderm patch 5%. The 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, 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. The records show that the patient was prescribed Lidoderm patches prior to 11/17/2014. Lidoderm patches are only indicated for patients with peripheral localized neuropathic pain which this patient does not present with. The request is not medically necessary.

**Soma 350 mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 65.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 29.

**Decision rationale:** This patient presents with upper back, low back, right foot, right buttock, and right thigh pain. The treater is requesting Soma 350 mg. The MTUS Guidelines page 29 on Carisoprodol (Soma) states that it is not recommended. This medication is not indicated for long-term use. Carisoprodol is commonly prescribed centrally acting skeletal muscle relaxant. Its primary active metabolite is meprobamate (a Schedule 4 Controlled Substance). The records show that the patient was prescribed Soma on 05/10/2013. In this case, Soma is not supported by the MTUS guidelines for long-term use. The request is not medically necessary.