

Case Number:	CM14-0214196		
Date Assigned:	01/07/2015	Date of Injury:	10/01/2000
Decision Date:	03/03/2015	UR Denial Date:	12/05/2014
Priority:	Standard	Application Received:	12/22/2014

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 41 year old patient with date of injury of 10/01/2000. Medical records indicate the patient is undergoing treatment for cumulative trauma overuse disorder, right carpal tunnel syndrome, status post right carpal tunnel release, chronic right shoulder impingement syndrome, chronic lumbosacral strain, s/p L5-S1 lumbar laminectomy. Subjective complaints include neck pain, radiating to right upper extremity into fingers with numbness and tingling, diminished cervical range of motion, low back pain radiating into bilateral lower extremities down to knees, left greater than right with numbness and tingling; pain rated 6/10 and described as constant. Objective findings include 2cm incision over the midline of lower lumbar spine, tenderness to palpation over the left paralumbar region with paralumbar muscle spasm, range of motion of back - forward flexion fingertips 4 inches from floor, extension 30 degrees, lateral bending fingertips on fibular heads, rotation to right and left 30 degrees; cervical range of motion - rotation to left and right 80 degrees, lateral bending ear on the shoulder bilaterally, forward flexion with chin on chest, extension 30 degrees; tenderness to palpation over the right trapezial, rhomboid and bilateral paracervical regions with appreciable muscle spasm. MRI of cervical spine date 11/13/2013 revealed no significant interval change since the exam on 10/13/2011, a regional focus of myelomalacia in the cervical cord at the C5-C6 level on the prior study is less apparent today, but there is no associated cord atrophy; stable moderate degenerative disc disease with spondylosis and a 2mm retrolisthesis C5-C6; there is milder degenerative disc disease at C4-C5 which has not progressed; C4-C5 partial effacement thecal sac with a broad-based stable

disc bulge, no change in right uncovertebral joint hypertrophy and mild foraminal stenosis; C5-C6 broad-based posterior disc osteophyte complex moderately effacing the thecal sac with mild acquired central stenosis, bilateral uncovertebral joint hypertrophy is greater on the right with moderate peripheral narrowing. MRI of lumbar spine dated 06/28/2013 revealed in the interval since the prior study the patient has undergone surgery with small laminectomy on the left side at L5, there is no significant narrowing of the left lateral recess on the current study; there is enhancing granulation/scar tissue in the operative bed and left side of the thecal sac, this is diffuse with no focal enhancement, displacement of the S1 nerve rootlet or other significant finding; 3mm of central/left paracentral disc bulging with a small annular fissure is stable at the L5-S1 level with no canal stenosis or foraminal narrowing evident; at L4-L5 there is only minor annular disc bulging of approximately 1 mm with mild facet arthropathy and no canal, lateral recess or foraminal narrowing; remainder of the visualized levels are within normal limits and unchanged compared to the prior study. Treatment has consisted of 4 pronged cane, surgical intervention, Lyrica, Eszopiclone, Norco, Soma, Cymbalta, Lidoderm patch and Lunesta. The utilization review determination was rendered on 12/05/2014 recommending non-certification of Lidocaine pad 5% #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidocaine pad 5% #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams

Decision rationale: MTUS and ODG recommend usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." ODG also states that topical lidocaine is appropriate in usage as patch under certain criteria, but that "no other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain." MTUS states regarding lidocaine, "Neuropathic pain 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 indicates lidocaine "Non-neuropathic pain: Not recommended." The medical records do not indicate failure of first-line therapy for neuropathic pain and lidocaine is also not indicated for non-neuropathic pain. ODG states regarding lidocaine topical patch, "This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia". Medical documents do not document the patient as having post-herpetic neuralgia. The treating physician has not provided documentation of increased functional improvement with the use of this medication. As such, the request for Lidocaine pad 5% #90 is not medically necessary.

