

<b>Case Number:</b>	CM15-0113246		
<b>Date Assigned:</b>	06/19/2015	<b>Date of Injury:</b>	03/16/1995
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	05/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### 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 57 year old female, who sustained an industrial injury on 03/16/1995. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having lumbar radiculitis, headaches unclassified, ongoing complex regional pain syndrome to the bilateral upper extremities, other chronic pain, status post shoulder surgery. Treatment and diagnostic studies to date has included above noted procedure, medication regimen, Toradol injection, x-ray of the left shoulder, x-ray of the chest, x-ray of the lumbar spine, status post right lumbar sympathetic block, and pool therapy. In a progress note dated 04/27/2015 the treating physician reports complaints of constant, burning, electrical, pins and needles type of neck pain that radiates to the right upper extremity along with tingling to the bilateral upper extremities, and frequent and severe muscle spasms to the neck. The injured worker has complaints of pain to the low back that radiates to the bilateral lower extremity with numbness, complaints of aching, stabbing pain to the right arm, complaints of pain to the bilateral lower extremities, and complaints of worsening insomnia with ongoing pain. Examination reveals tenderness and swelling to the left upper extremity, tenderness to the right lower extremity, decreased range of motion secondary to pain to the left shoulder, left elbow, left wrist, and left hand, decreased strength to the left upper extremity, allodynia to the right upper extremity and the right lower extremity, hypersensitivity to the right lower extremity, discoloration to the right upper extremity, and hyperhidrosis to the bilateral hands. The injured worker's current medication regimen includes Gabapentin, Hydrocodone/ Acetaminophen, Lidoderm 5% Patch, Nucynta ER, Tizanidine, and Restoril. The

injured worker's current pain level is rated a 6 out of 10 with use of her medication regimen and is rated a 10 out of 10 without use of her current medication regimen. The treating physician notes that with the use of the injured worker's current medication regimen and pool therapy the injured worker has 60% functional improvement with activities of daily living and also has an improvement in the quality of life. The documentation did not indicate any gastrointestinal symptoms such as nausea. The treating physician requested the medications of Compazine 10mg with a quantity of 60 with 1 refill to be used as needed for nausea and Lidoderm Patch 5% with a quantity of 30 with 1 refill noting current use of this medication along with the treating physician noting that this medication is beneficial to the injured worker.

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

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

#### **1 prescription for Lidoderm patch 5% # 30 with 1 refill: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** The California chronic pain medical treatment guidelines section on topical lidocaine states: Lidocaine Indication: 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). 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. Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritics. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007, the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. (Argoff, 2006) (Dworkin, 2007) (Khaliq-Cochrane, 2007) (Knotkova, 2007) (Lexi-Comp, 2008) Non-neuropathic pain: Not recommended. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. (Scudds, 1995) This medication is recommended for localized peripheral pain. Review of the provided medical documentation meets criteria as outlined above as the patient has neuropathic pain with failure of first-line agents. The request is medically necessary.

**1 prescription for Compazine 10mg #60 with 1 refill: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic): Antiemetics.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation PDR, compazine.

**Decision rationale:** The California MTUS, ODG and ACOEM do not specifically address the requested service. The physician desk reference states the requested medication is indicated in the treatment of nausea. The patient does have the diagnosis of nausea associated with industrial incident. The patient has no contraindications to the medication. The request is medically necessary.