

Case Number:	CM15-0122259		
Date Assigned:	07/06/2015	Date of Injury:	02/13/2013
Decision Date:	07/31/2015	UR Denial Date:	06/23/2015
Priority:	Standard	Application Received:	06/24/2015

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 42 year old female patient who sustained an industrial injury on 02/13/2013. A recent follow up dated 05/18/2015 reported subjective complaint of having chronic neck pain secondary to cervical disc degeneration. She has neck pain that radiates into her upper back and at times does radiate into her bilateral upper extremities. She has not had medications so there is noted increased pain level. She continues working full time duty and is tolerating it generally well. She also indicated having increased pain at the end of a work day which is associated with increased headaches. She takes Venlafaxine which does help with her symptom of depression. Electric nerve conduction study performed on 05/30/2014 revealed bilateral cervical radiculitis or mild cervical stenosis is suggested. On 05/19/2014 she underwent a cervical magnetic resonance imaging study that showed multi-level degenerative disc disease with small disc osteophyte complexes at C5-6 mildly effacing the ventral thecal sac. Current medications are: Colace, Venlafaxine, Lidoderm, and Morphine Sulphate ER. She was diagnosed with degeneration cervical disc, headache tension, posttraumatic stress disorder and depression. The MSo4 was discontinued and a trial of Buprenorphine was started: and continue with cognitive behavioral therapy. The patient is permanent and stationary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm 5% Patch % (700mg/patch), one Patch to skin every 12 hours on and 12 hours off, #30 DOS: 05/18/15: Upheld

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): 111-113.

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. There is no documentation of failure of first line neuropathic pain medications. Therefore criteria as set forth by the California MTUS as outlined above have not been met and the request is not medically necessary.