

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: September 2, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lidoderm 5 percent Patch Apply to Right Knee 12hrs/day, Off 12hrs/day #30,
Soma 350mg 1 po up to TID PRN spasms #90/Month

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This physician is Board Certified in Rehabilitation and Physical Medicine with over 18 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on the job on xx/xx/xx, diagnosed with reflex sympathetic dystrophy in the right lower extremity. The claimant with significant right knee pain, and chronic swelling, ambulates with IROM brace.

02-10-12: Spine Lumbar Comp w/Bend views. Impression: Negative lumbar spine exam with no acute osseous abnormality.

02-10-12: Spine lumbar wo contrast MRI. Impression: No significant degenerative disease within the lumbar spine.

03-27-12: EMG Report. Interpretation: EMG of the lower extremities and lumbosacral paraspinals is within normal limits. A repeat EMG study may be considered in 6-12 months if clinically worsening or indicated. There is no

neurophysiologic evidence of peripheral neuropathy/myopathy. No evidence of L3-S1 radiculopathy/peroneal neuropathy/posterior tibial neuropathy/sciatic neuropathy/lumbosacral plexopathy on the either side. Clinical correlation: Clinically, claimant may have musculoskeletal pain in the lower extremity on the left. There is no evidence of complex regional pain syndrome spreading to the left side. Claimant does have complex regional pain syndrome around the knee on the right. However, the numbness in the distal right leg remains unexplained. A component of psychocomatic symptoms may be considered. Conservative treatment is recommended, including pain management.

12-13-12: Office Visit. Chief complaint: right knee pain, right hip pain, LBP, RLE pain. Claimant stated his pain has significantly increased today because the cooler weather has him wearing long pants, RSD related symptoms do not like long garments. Past surgical history: right knee x 6. ROS: Musculoskeletal: complaints of joint pain, back pain, joint swelling. Neurologic: complaints of numbness, tingling. PE: Stable CPM exam. Assessment: dystrophy, reflex sympathetic, lower limb, unchanged; WC1 knee injury, right, unchanged. The claimant's pain regimen is stable. Recommend wearing a garment that fits more snugly still than even his blue jeans do, so that there is much movement of the cloth on the skin itself, which would minimize the symptoms. Claimant does not want to have surgery. Plan: RX: Lidoderm 5% patch apply to right knee 12 hrs per day, off 12 hrs, Lunesta 3mg, Lyrica 25mg, Soma 350mg, Norco 10/325, Opana ER 10mg. New Orders: counseling & coordination of care >50%.

02-07-13: Office Visit. Chief complaint: right leg, hip & lower back pain. Over the last month or two he has been noticing allodynic symptoms that are spreading more distally in his right leg and also perhaps a bit more proximally above the knee, especially medially in the thigh. He denies any spread of the symptoms to the left leg per se at the juncture. He is worried that these symptoms represent a new problem. He has noted it is also changing his gait where he walks more on the outer part of his foot and with his foot rotated externally as well. These symptoms showed possible sympathetic dystrophy that is trying to generalize from its typical region. ROS: Musculoskeletal: complaints of joint pain, back pain, joint swelling. Neurologic: complaints of numbness, tingling. PE: Musculoskeletal: RLE: There are allodynic features down over the foot and ankle that also has hyperpathic continuation for 30 seconds or so after the stimulus ends. These symptoms are very worrisome that RSD may be trying to generalize in his right leg. He also has similar findings in the proximal medial thigh on the right side as well. Assessment: dystrophy, reflex sympathetic, lower limb, as deteriorated. Recommend lumbar sympathetic block on the right side to try to establish whether these symptoms distally in the right leg are indeed sympathetically maintained and at the same time hopefully re-set the sympathetic nervous system so that the symptoms are not as generalized. Recommend a spinal cord stimulator if the block proves to be short lived. Plan: RX: Lunesta 3mg, Lidoderm 5% patch, Lunesta 3mg, Lyrica 25mg, Soma 350mg, Norco 10/325, Opana ER 10mg.

06-25-13: Office Visit. Chief complaint: LBP, RLE pain, right knee and left arm and shoulder pain and sensitive to touch x 2 weeks. Claimant complained that his left arm symptoms are getting worse and could represent a migration of the RSD to that part of his body. He denies trauma to this part of his body. The symptoms have an allodynic property to them over the lateral aspect of the forearm with burning dysesthesia there as well. Job Status: not able to work because of pain, 3-5 years since worked regularly. ROS: Musculoskeletal: complaints of joint pain, back pain, joint swelling. Neurologic: complaints of numbness, tingling. PE: Musculoskeletal: LEE: The temperature, however, is cool when compared to the right leg, which is cool enough to begin with. Neurologic: Sensation: Allodynic features are present in a non dermatomal fashion in the left knee and below the left knee in the skin area. Assessment: dystrophy, reflex sympathetic, lower limb, unchanged. Comments: Refilled medications. Claimant asked to increase his medicines because they are not as effective as they used to be given the escalating symptoms in the left leg and now the symptoms in the left arm as well. Request declined until we see what the sympathetic block does in the left leg. Plan: Lidoderm 5% patch, Lunesta 3mg, Lyrica 25mg, Soma 350mg, Norco 10/325, Opana ER 10mg.

07-02-13: Out Patient Op Reports. Claimant underwent a left L2 and L4 level lumbar sympathetic block today. He had about a 2 degree temperature rise in the left leg over baseline, but also noted was approximately a 1 degree temperature rise in the right leg, which no block was completed on that side. Preliminarily, claimant is reporting improvement in his left leg symptoms. Follow up next week.

07-02-13: Operative Report. Preoperative Diagnoses: 1. History of RSD/CRPS, right lower extremity. 2. Suspicion of RSD/CRPS spread to the left lower extremity. Postoperative Diagnoses: 1. History of RSD/CRPS, right lower extremity. 2. Suspicion of RSD/CRPS spread to the left lower extremity.

07-10-13: Office Visit. Chief complaint: BLE (knee) pain, LBP, LUE pain. The duration of improvement in the symptoms s/p block in both left leg and arm was approximately 8-12 hours and then the symptoms came back to their previous level. The arm symptoms in particular stayed gone about the same amount of time that the leg symptoms did, which strongly suggests that the arm symptom changes were the result of the sympathetic block in his lumbar spine. Spinal cord stimulator is no longer a very viable option for him to consider if the left arm symptoms do prove to be origin though before we can say unequivocally that the left arm symptoms are sympathetic in their origin though before we can say unequivocally that those symptoms are linked to the lower extremity symptoms. ROS: complaints of joint pain, back pain, joint swelling. Neurologic: complaints of numbness, tingling. PE: Musculoskeletal: LUE: There is allodynia that is sleeve like in its distribution and thus non dermatomal from approximately the mid biceps area and triceps area down to the mid forearm area. The allodynia then returns to normal sensation function above and below this distribution. The hair growth pattern appears normal in the left arm. There is no hyperhidrosis. LLE: The allodynic symptoms are unchanged from the previous exams and are nondermatomal in their distribution as well. Temperature differential is difficult to

measure because his right leg is temperature variable with his RSD there. Assessment: reflex sympathetic dystrophy, LUE; dystrophy, reflex sympathetic, lower limb, bilateral. Comment: RSD of the left lower extremity, making the lower extremity RSD symptom field bilateral in its distribution now, and possibly LUE as well. Requested sympathetic block on the left side at the stellate ganglion to prove whether that is sympathetically driven symptoms or not. Agreed with claimants' prescriptions for a wheelchair to help his ambulatory needs with long distance travels. Plan: Opana ER 10mg, Norco 10/325, Soma 350mg, Lyrica 25mg, Lunesta 3mg, Lidoderm 5% Patch.

07-22-13: Office Visit. Chief complaint: BLE pain, LUE pain, mid-LBP. The claimant's painful symptoms continue to affect his right leg predominantly, but he has also now been proven to have a sympathetic component to his symptoms in the left leg, which by spillover effect had an effect on his left upper extremity symptoms as well. We are now in the process of seeking permission to perform a sympathetic block in the neck on the left side to confirm whether the left arm symptoms are sympathetically driven or not. His medication regimen continues to afford him modest improvement in his symptoms. ROS: complaints of joint pain, back pain, joint swelling. Neurologic: complaints of numbness, tingling. PE: Musculoskeletal: LLE: The allodynic symptoms are unchanged from the previous exams and are nondermatomal in their distribution as well. Temperature differential is difficult to measure because his right leg is temperature variable with his RSD there. Neurologic: Sensation: Allodynic features are present in a non dermatomal fashion in the left knee and below the left knee in the shin area. Assessment: dystrophy, reflex sympathetic, lower limb, bilateral, unchanged; reflex sympathetic dystrophy, LUE, unchanged; WC1 Knee injury, right, unchanged. Prescriptions will be continued unchanged. Medication regimen is medically necessary for control for his chronic pain complaints, which are from RSD/CRPS, which is now affecting multiple limbs. These medications, although risky for addiction, etc, nonetheless give the claimant a modicum of symptomatic relief that affords him some reprieve from his complaints. Plan: Lidoderm 5% patch, Lunesta 3mg, Lyrica 25mg, Soma 350mg, Norco 10/325, Opana ER 10mg. Follow up in 1 month.

07-22-13: Letter of Medical Necessity. The claimant has a chronic pain condition for which it is medically necessary for him to receive opiate medications for control of the painful symptoms that his condition causes. It is intent that these medicines be continued uninterrupted.

08-06-13: Operative Report. Preoperative Diagnoses: 1. Knee pain. 2. Reflex sympathetic dystrophy. 3. Left upper extremity pain. 4. Question of RSD/CRPS left upper extremity. Postoperative Diagnoses: 1. Knee pain. 2. Reflex sympathetic dystrophy. 3. Left upper extremity pain. 4. Question of RSD/CRPS left upper extremity.

02-03-14: Pre-Authorization. Request Treatment: 1. Lidoderm 5% patch apply to right knee 12 hrs/day, off 12hrs/day #30 patches/mth. 2. Soma 350mg 1 PO up to TID PRN spasms #90/mth. These medications are medically necessary for

control of his chronic pain complaints. The claimant finds that the Lidoderm patch applied to the right knee to be very beneficial at alleviating some of the most sensitive areas of his allodynic response related to RSD. Soma is effective in managing his muscle spasms associated with the knee and back issues.

02-27-14: Office Visit. Chief complaint: right knee pain, 6/10. The claimant is here for medication follow-up visit. He reported that he is starting to get allodynic and hyperpathic symptoms in his right upper extremity. The claimant's medications for his compensable symptoms, which are those in his right leg, work just as well for the other areas of his body where he has similar symptoms. He denies any abuse or diversion of his medications. ROS: complaints of joint pain, back pain, joint swelling. Neurologic: complaints of numbness, tingling. Assessment: dystrophy, reflex sympathetic, lower limb, unchanged. Medications will continue unchanged. RSD symptoms may be spreading to the right arm as well as his left arm. We are gravely concerned that they are affecting his bilateral lower extremities as well. Basically, RSD is now generalized to all four limbs based on clinical features alone. We have not been able to prove that with his insurance carrier's current position about compensable injury. Plan: Lidoderm 5% patch, Lunesta 3mg, Lyrica 25mg, Soma 350mg, Norco 10/325, Opana ER 40mg. Follow up in one month.

04-29-14: Operative Report. Preoperative Diagnosis: Right upper extremity pain, suspicious for reflex sympathetic dystrophy/complex regional pain syndrome. Postoperative Diagnosis: Right upper extremity pain, suspicious for reflex sympathetic dystrophy/complex regional pain syndrome.

05-27-14: Office Visit. Chief complaint: right knee pain, LBP, 6/10. Claimant underwent a recent right stellate ganglion block. The claimant's insurance company through peer review has decided that he no longer needs to be on Opana and they have recommended that he be weaned off of that medication over a 15-20 day interval. The claimant's pain will be escalated if his pain medicine is discontinued and his ability to function in activities of daily living, although not great now, would certainly be much worse without the medication. The claimant reported that his right sympathetic block at stellate ganglion level achieved a nice reduction of near complete relief of his right arm symptoms that lasted well past the local anesthetic phase of his injection for approximately 5 days in his estimation. The degree of relief that he describes was near total relief, which suggests that the RSD that originated in his right leg has now spread also to his right arm, if not other regions of his body as well, which we have previously not been able to convince the insurance carrier to allow treatment for. ROS: complaints of joint pain, back pain, joint swelling. Neurologic: complaints of numbness, tingling. PE: Musculoskeletal: RUE: There is swelling present in the right hand and forearm area when compared to the left. The temperature seems to be warmer in the right hand than the left and the skin color is also of a redder complexion on the right than the left. RLE: There are allodynic features down over the foot and ankle area that also have hyperpathic continuation for 30 seconds or so after stimulus ends. These symptoms are very worrisome that RSD may be trying to generalize the right leg. He also has similar findings in the

proximal medial thigh on the right side as well. Neurologic: Sensation: Allodynic features are present in the proximal right arm, more so than the distal, but there is allodynia throughout. Assessment: reflex sympathetic dystrophy, RUE, unchanged; dystrophy, reflex sympathetic, lower limb, bilateral, unchanged; reflex sympathetic dystrophy, LUE unchanged; dystrophy, reflex sympathetic, lower limb, unchanged. Advised claimant to inform his adjuster that we have no intention of complying with the weaning schedule. The claimant's pain will be extraordinarily severe without this medicine. Plan: Lunesta 3mg, Lyrica 25mg, Soma 350mg, Norco 10/325, Opana ER 40mg, Lidoderm 5% patch. Follow up in one month.

05-27-14: Pre-Authorization. Requested Treatment: Lidoderm & Soma. Diagnosis: Reflex sympathetic dystrophy-337.20, Right knee injury-959.7, Lumbago-724.2, Lumbar radiculopathy-724.4. The claimant is prescribed Opana ER, Norco, Lyrica, Lunesta, Soma, and Lidoderm patches for the treatment of his work related injury. IT has been reported that Soma and Lidoderm require prior-authorization. These medications are medically necessary for control of his chronic pain complaints. The claimant finds the Lidoderm patch applied to the right knee to be very beneficial at alleviating some of the most sensitive areas of his allodynic response related to RSD. Soma is effective in managing his muscle spasms associated with the knee and back issues.

06-02-14: UR. Reason for denial: The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The mechanism of injury was not stated. Medications included a Lidoderm patch applied to the right knee 12 hours per day on and 12 hours per day off, Lunesta 3 mg 1 every night, Lyrica 25 mg twice a day, Soma 350 mg 1 up to 3 times a day for spasming, Norco 10/325 mg 1 to 2 three times a day up to 6 per day, and Opana extended release 40 mg XR 1 every 12 hours. Surgical history included right knee surgery times 6, dates not stated. Diagnostic studies were not stated. Other therapies included stellate ganglion blocks, physical therapy, and medications. The claimant is a male who reported an injury on xx/xx/xx. Physical findings included allodynic features over the foot and ankle of the right lower extremity hyperpathic continuation for 30 seconds or so after the stimulus ends, and allodynic features in the proximal right arm. The ODG recommend carisoprodol for very short courses of treatment for acute exacerbations of pain. The clinical documentation submitted for review does indicate that the claimant has been on this medication since at least 03/2014. This exceeds the guideline recommendations. There are no exceptional factors within the documentation to support extending treatment beyond guideline recommendations. Additionally, the California Medical Treatment Utilization Schedule recommends ongoing use of Lidoderm patches be supported by documentation of functional benefit and evidence of pain relief. The clinical documentation submitted for review does indicate that the claimant has been on this medication since at least 03/2014. However, there is no documentation of functional benefit or pain relief resulting from medication usage. As such, the requested Lidoderm 5 percent Patch Apply to Right Knee 12hrs/day, Off 12hrs/day #30 patches/month Soma 350mg 1 po up to TID PRN spasms #90/ month is non-certified.

06-18-14: Request for Reconsideration. The claimant has RSD that began in his right leg, progressed to the left leg, and has moved into the left upper extremity as well. RSD has the potential to generalize to other regions of the body, and each of these progressions has been proven with a diagnostic sympathetic block to be sympathetically maintained painful symptoms. He is treated for chronic pain complaints, which are related to his work injury and the sequelae of RSD that developed after the injury's multiple attempted surgical remedies, now affecting multiple limbs. His pain is chronic and severe, and he will likely need long-term medication management to allow him to remain functional.

07-14-14: UR. Reason for denial: The request for a Lidoderm patch 5 percent for the right knee, quantity 30 and Soma 350mg, quantity 90 is not recommended as medically necessary based on review of the clinical documentation submitted as well as current evidence based guidelines. This is an appeal of a prior denial in which the previous reviewer opined that Soma is not indicated for long term treatment of chronic pain and there was no documentation regarding functional benefits obtained with the continued use of Lidoderm patches. The claimant has been followed for complaints of chronic pain in the left lower extremity consistent with RSD. The claimant was reported to have a good quality of life with the medications. The claimant did have recent right sympathetic blocks with near complete relief of his right upper extremity symptoms. No specific pain score changes were noted with the use of medications. continually indicated that both medications were effective for the claimant's symptoms. Although the claimant has continued to have ingoing neuropathic findings on physical exam which would support continuation of Lidoderm patches, current evidence based guidelines do not recommend the long term use of Soma due to lack of evidence regarding the efficacy of this medication and the risks for dependence and addiction. As such, this reviewer would not recommend certification for the request submitted.

08-07-14: Office Visit. Chief complaint: Right knee pain, LBP, 6/10. The claimant has attempted to ease himself off the Opana himself. When he cut his dosage in half, it did not go oaky when it came down to one-fourth of the dosage. He started having quite a bit of anxiety and diaphoresis and got a good taste of what the withdrawal symptoms would be like and basically he panicked. At that point he began calling the insurance company and asked them to not put him through this distress. The insurance company's answer, which was couched to him by his adjustor, was that they would acquiesce in their position to a weaning schedule that would be implemented and established by me. The claimant asked me to initiate the weaning schedule for his Opana and "I have no intention of taking him off Opana and that this was not my treatment plan and that in fact it was the insurance's plan, which was not appropriate for him". The claimant was re-instructed today as the importance of recognizing the withdrawal symptoms which he apparently has already demonstrated the ability to do quite well. Should he experience those symptoms again when his Opana supply runs out, then he is instructed to contact my office and to notify me that those symptoms are becoming unbearable and will instruct him to present to the emergency room for admission for detox there. This is what is recommended out of medical necessity

to assist the claimant with the withdrawal symptoms that are being initiated by the insurance company's treatment plan, which "I do not endorse". Assessment: dystrophy, reflex sympathetic, lower limb, bilateral, unchanged. Plan: Opana ER 40mg, Norco 10/325, Soma 350mg, Lyrica 25mg, Lunesta 3mg, Lidoderm 5% patch. Follow up as needed

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Previous adverse determinations are UPHELD/AGREED UPON given prolonged use of Soma and Lidoderm patches at least since 12/13/12 without documented decrease in pain (no VAS pain score on and off medications), no reduction in other medications due to use of these medications, no documented improvement in function (with no documented functional history, activity level, or work status), and, other than the exact same exam of allodynia and hyperpathic sensation over the foot and ankle, no examination of/improvement in the body parts for which the medications are prescribed - no exam of the lumbar spine, no exam of the right knee - no range of motion, no tenderness, no spasm, no manual muscle testing, no provocative maneuvers, no functional exam (sitting tolerance, sit to stand, gait). There is also no history regarding how the medications are actually taken or used (number per day) as opposed to how they are prescribed. There is no documented urine drug testing regarding compliance with the medication regimen. There is no documentation of any adverse side effects attributable to the medications. There is no documentation of self directed pain modulation techniques such as stretching, home exercise program, modalities (such as ice, heat, and/or electrical stimulation), desensitization techniques, and activity modification. There is question of trial of over the counter topical agents, and if so, the results. There is question as to the trial of other medications specifically for muscle spasm. There is question regarding psychosocial barriers to recovery, the consideration of the effect of the Soma for sedation and treatment of anxiety, any consideration of evaluation by Psychology and/ or Psychiatry regarding counseling, instruction in relaxation and pain modulation techniques, and possibility of other psychotropic medications more effective in treatment of associated anxiety. Therefore, after review of medical records and documentation provided, the request for Lidoderm 5 percent Patch Apply to Right Knee 12hrs/day, Off 12hrs/day #30, Soma 350mg 1 po up to TID PRN spasms #90/Month is denied.

Per ODG:

<p>Carisoprodol (Soma®)</p>	<p>Not recommended. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy. (AHFS, 2008) This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a Schedule-IV controlled substance). As of January 2012, carisoprodol is scheduled by the DEA as a Schedule IV medication. (DEA, 2012) It has been suggested that the main effect is due to generalized sedation and treatment of anxiety.</p> <p><i>Beers criteria:</i> The AGS updated Beers criteria for inappropriate medication use includes carisoprodol. This is a list of potentially inappropriate medications for older adults. (AGS, 2012)</p> <p><i>Abuse:</i> Abuse has been noted for sedative and relaxant effects. In regular abusers the</p>
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	<p>main concern is the accumulation of meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. This includes the following: (1) increasing sedation of benzodiazepines or alcohol; (2) use to prevent side effects of cocaine; (3) use with tramadol to produce relaxation and euphoria; (4) as a combination with hydrocodone, an effect that some abusers claim is similar to heroin (referred to as a “Las Vegas Cocktail”); & (5) as a combination with codeine (referred to as “Soma Coma”). (Reeves, 1999) (Reeves, 2001) (Reeves, 2008) (Schears, 2004) (Owens, 2007) (Reeves, 2012) There was a 300% increase in numbers of emergency room episodes related to carisoprodol from 1994 to 2005. (DHSS, 2005) Hospital emergency department visits involving the misuse of carisoprodol have doubled over five years, study shows. (SAMHSA, 2011)</p> <p><i>Intoxication signs:</i> Intoxication appears to include subdued consciousness, decreased cognitive function, and abnormalities of the eyes, vestibular function, appearance, gait and motor function. Intoxication includes the effects of both carisoprodol and meprobamate, both of which act on different neurotransmitters. (Bramness, 2007) (Bramness, 2004)</p> <p><i>Withdrawal:</i> A withdrawal syndrome has been documented that consists of insomnia, vomiting, tremors, muscle twitching, anxiety, and ataxia when abrupt discontinuation of large doses occurs. This is similar to withdrawal from meprobamate. (Reeves, 2010) (Reeves, 2007) (Reeves, 2004)</p> <p><i>Weaning:</i> There is little research in terms of weaning of high dose carisoprodol and there is no standard treatment regimen for patients with known dependence. Most treatment includes treatment for symptomatic complaints of withdrawal. Another option is to switch to phenobarbital to prevent withdrawal with subsequent tapering. A maximum dose of phenobarbital is 500 mg/day and the taper is 30 mg/day with a slower taper in an outpatient setting. Tapering should be individualized for each patient. (Boothby, 2003) For more information and references, see Muscle relaxants. See also Weaning, carisoprodol (Soma®).</p>
Lidoderm® (lidocaine patch)	<p>Criteria for use of Lidoderm patches:</p> <ul style="list-style-type: none"> (a) Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. (b) There should be evidence of a trial of first-line neuropathy medications (tricyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). (c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. (d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale. (e) The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day). (f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks). (g) It is generally recommended that no other medication changes be made during the trial period. (h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued. (i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**