

<b>Case Number:</b>	CM13-0061077		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	04/29/1997
<b>Decision Date:</b>	07/07/2014	<b>UR Denial Date:</b>	11/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/04/2013

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and Orthopedic Sports Medicine and is licensed to practice in New York. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 62 year old female injured on 04/29/97 due to an undisclosed mechanism of injury. Neither the specific injury sustained nor the initial treatments rendered were addressed in the clinical documentation submitted for review. Current diagnoses included left shoulder impingement status post decompression, right shoulder impingement status post arthroscopy, neck pain with muscle spasms, and elements of depression, anxiety, and insomnia. Clinical note dated 01/02/14 indicated the patient presenting with complaints of bilateral shoulder pain on a daily basis rated at 8/10 on pain scale. The patient was taking Tylenol over the counter with only minimal pain relief. The patient reported spasms with numbness and tingling. The patient was currently undergoing psychotherapy and electrical stimulation for depressive symptoms in addition to lexapro. There were no further medications listed. Lidopro 4 oz has been requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LIDOPRO 4 OZ:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111.

**Decision rationale:** As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Lidocaine is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points and 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). Therefore LIDOPRO 4 OZ cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.