

Case Number:	CM13-0067089		
Date Assigned:	01/03/2014	Date of Injury:	12/07/2010
Decision Date:	07/24/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/17/2013

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 Internal Medicine and is licensed to practice in Arizona. 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:

This is a 49-year-old female who in December 2010, tripped over a mat with her left foot and landed on her hands and knees. Her primary areas of pain are at the right shoulder and lumbar spine. For the shoulder, she underwent a Mumford decompression in 2011. She still reports significant pain, which actually flared from Hydrotherapy in October. An MRI obtained in November 2013 showed no impingement of the rotator cuff; but, there was a partial thickness supraspinatus tear. The patient did get an arthroscopic steroid injection. For the lumbar spine, in April 2013, this patient had medial branch blocks at L3-4, L4-5 and L5-S1, which provided good relief. She subsequently underwent Radiofrequency Ablation at these sites. She did have an electromyogram (EMG) that confirmed a left S1 radiculopathy. The patient reported to a physical therapist that she had been applying a Lidocaine patch at the lumbar spine at night. She did state that her back pain was doing better after undergoing the Radiofrequency Ablation. She did claim that her worse pain was at the shoulder. She described it as severe, especially at night. For this, the patient had been placing a Lidocaine patch before bedtime; but, because it was not certified she no longer was using it and her night time shoulder pain worsened. This patient uses Methadone 20mg/day and Norco 10/325mg, one (1) pill twice daily for pain. She has an allergy/intolerance to all of the anti-inflammatories, specifically Mobic, Toradol and aspirin. There is no documentation as to whether a Tricyclic or serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant or whether one (1) of the anticonvulsants, gabapentin or Lyrica has been tried.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidocaine pad 5%, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine patch); Topical analgesics Page(s): 56, 57, 112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Return-To-Work Pathways for Selected Generalized Pain Syndromes.

Decision rationale: The Chronic Pain Guidelines recommend a lidocaine patch for localized peripheral pain only, after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). The Official Disability Guidelines describes the criteria for the use of the Lidoderm patches, which additionally states it is not recommended for osteoarthritis or treatment of myofascial pain/trigger points. 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 is generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain.) Perhaps, this could also apply to the shoulder. The shoulder is not generally regarded as being painful from neuropathic mechanisms; but, because the patient has already used it, and claimed benefit, perhaps there is some nerve pain. The MRI did not see any impingement. The lumbar back does have a neuropathic component as verified by the electromyography (EMG). However, the patient's back was doing well from the radio frequency (RF) ablation, making an ongoing need for Lidocaine in this area undetermined. The Lidocaine patch for the shoulder and the lumbar back is deemed not medically necessary. It is supposed to be a second line of therapy. There has been no trial of any of the first line therapies, such as one of the antidepressants or anticonvulsants as mentioned above. It is possible they could offer even more relief than what this patient has been getting with the patch.