MAXIMUS Federal Services

Case Number:	CM14-0101510		
Date Assigned:	07/30/2014	Date of Injury:	07/12/2010
Decision Date:	11/05/2014	UR Denial Date:	06/12/2014
Priority:	Standard	Application Received:	07/01/2014

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 Anesthesiologist, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 48-year-old female who reported an injury on 07/12/2010. The mechanism of injury was not provided. The injured worker's diagnoses included bilateral epicondylitis, tendinitis of the left elbow, and ganglion cyst of the right wrist. The injured worker's past treatments included physical therapy, injections, and medication. There were no significant diagnostic studies included. The injured worker's surgical history included a ganglion excision on 05/20/2013. On 06/05/2014, the injured worker reported approximately 85% resolution of elbow pain with the injection in the prior 2 weeks. She reported that there was still some pain with elbow extension, and that she was able to lift and carry more. Upon physical examination, the left elbow was noted to have full range of motion but with pain upon extension and supination. She had slightly decreased supination strength. A negative Tinel's at the elbow was noted. There was no noted pain with resisted wrist extension, resisted wrist flexion, and no tenderness to palpation over the medial epicondyle/cubital tunnel. The injured worker's medications included a Flector patch and Lidoderm patch. The request was for lidocaine patches 5% #30 for pain. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidocaine Patches 5% #30 refills 3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch), Page(s): pages 56-57..

Decision rationale: The request for Lidocaine Patches 5% #30 refills 3 is not medically necessary. The California MTUS Guidelines may recommend Lidoderm for localized peripheral pain after there has been evidence of a trial of first line therapy. This is not a first line treatment and is only FDA approved for postherpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. The injured worker reported approximately 85% resolution of elbow pain with the previous injection. The documentation indicated that the patient had been using the Lidoderm patch since at least 04/25/2014. The efficacy of the medication was not documented. The documentation did not provide evidence of a complete and thorough pain evaluation to include a quantified current pain, the least reported pain over the period since the last assessment, the intensity of pain after using the medication, and how long the pain relief lasts. The documentation did not provide evidence of significant objective functional improvement due to the use of Lidoderm. In the absence of documentation with sufficient evidence of significant objective functional improvement and documented evidence of an objective decrease in pain due to the use of Lidoderm, the request is not supported. Additionally, as the request is written, there is no frequency provided. Therefore, the request is not medically necessary.