

<b>Case Number:</b>	CM14-0107617		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	04/22/2009
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	06/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/10/2014

### 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 Anesthesiology, 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 58-year-old female who reported an injury on 04/22/2000. The mechanism of injury was noted to be a fall. The diagnoses were noted to be a rotator cuff sprain, lumbar and cervical sprains. The injured worker was noted to have prior treatments of physical therapy, psychotherapy and Functional Capacity Evaluation. Diagnostic testing was noted to be an MRI of the cervical spine there were no pertinent surgeries involved with this case. The injured worker's subjective complaints were noted to be constant right shoulder pain. The objective physical examination findings included right shoulder tenderness and restricted range of motion, right hand had decreased grip strength, tenderness to right paracervical muscles and limited range of motion. The injured worker was noted to use the medications gabapentin, baclofen and a Lidoderm patch. The treatment plan was for physical therapy and a home exercise program. The provider's rationale for the request was not noted. A Request for Authorization form was not provided with the documentation submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidocaine Pad 5% Day Supply: 30 Qty: 60 Refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Lidocaine Patch Page(s): 56-57.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**Decision rationale:** The request for lidocaine pad 5% day supply: 30, quantity 60 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines state Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED, such as Gabapentin or Lyrica). The documentation submitted for review does not indicate a failure of antidepressants or anticonvulsants. In addition, the provider's request fails to indicate a dosage frequency. As such, the request for lidocaine pad 5% day supply: 30, quantity 60 is not medically necessary.