

Case Number:	CM14-0014379		
Date Assigned:	02/21/2014	Date of Injury:	07/08/2003
Decision Date:	06/26/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/05/2014

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 reported an injury on 07/08/2003. The injured worker underwent a right shoulder arthroscopic SAD, debridement, and excision of the distal clavicle on 04/06/2010 and underwent a right knee arthroscopy medial meniscectomy and synovectomy on 05/05/2009, along with a partial medial meniscectomy of the left knee with patellofemoral chondroplasty on 04/02/2004. The documentation of 01/06/2014 revealed the injured worker had pain of a 6/10. Overall, the injured worker indicated she was doing better and had started tapering her narcotics. The diagnoses included degenerative joint disease cervical spine and left shoulder, degenerative joint disease lumbar spine, and postsurgical left knee pain, constant. The treatment plan included oxycodone ER 20 mg 1 tablet by mouth twice a day #30 and a discontinuation of oxycodone 10 mg. There was a request for a refill of Lidoderm patches times two 5% 12 hours on and 12 hours off #30 to be applied to the left shoulder and left knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

LIDODERM PATCH TIMES TWO, 5%, #30, ONE PATCH TO THE LEFT KNEE, 12 HOURS ON AND 12 HOURS OFF: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESIC.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
LIDODERM Page(s): 56, 57.

Decision rationale: The California MTUS Guidelines indicate that topical Lidoderm may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy, including a tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica. This is not a first line treatment and is only FDA approved for postherpetic neuralgia. There was a lack of documentation indicating the injured worker had postherpetic neuralgia. The clinical documentation indicated the request was for a refill; however, the duration of use could not be established. There was a lack of documentation of an objective decrease in pain and an objective increase in function with the use of the medication as it was indicated to be a refill. Therefore, the request for Lidoderm patch two 5% #30 1 patch to the left knee 12 hours on and 12 hours off is not medically necessary.