

<b>Case Number:</b>	CM14-0039323		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	08/10/2009
<b>Decision Date:</b>	08/22/2014	<b>UR Denial Date:</b>	03/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California and Washington. 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 69-year-old male who reported an injury on 08/10/2009 secondary to an unspecified mechanism of injury. The injured worker was evaluated on 03/25/2014 for reports of groin pain. The patient underwent a radiofrequency ablation and reported 50% pain relief for at least 1 month. The exam noted the patient had normal musculoskeletal range of motion. The patient was neurologically intact. There were no strength deficits or deep tendon reflex deficits noted. Decreased sensation to light touch was noted on the frontolateral left leg. Diagnoses included status post revision of a left inguinal hernia repair and persistent postsurgical pain syndrome. The treatment plan included a repeat radiofrequency ablation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm 5% (700mg/patch):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

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

**Decision rationale:** The request for Lidoderm 5% (700mg/patch) 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 therapies. There is a significant lack of objective evidence of peripheral pain and a lack of evidence of an evaluation of the efficacy of the prescribed medication. Furthermore, the request does not specify the specific body area for application. Therefore, due to the significant lack of clinical evidence of peripheral pain, an evaluation of the efficacy of the prescribed medication, and the lack of specific body part for application being included in the request, and the specific lack of body part for application and specific number of patches being requested not included in the request, the request for Lidoderm 5% (700mg/patch) is deemed not medically necessary.