

<b>Case Number:</b>	CM15-0106226		
<b>Date Assigned:</b>	06/10/2015	<b>Date of Injury:</b>	01/15/2009
<b>Decision Date:</b>	07/15/2015	<b>UR Denial Date:</b>	05/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Texas, California  
 Certification(s)/Specialty: Family Practice

### 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 63 year old male, who sustained an industrial injury on January 15, 2009. He reported being struck on the left side of his head and his left shoulder by a basket. The injured worker was diagnosed as having neck sprain, cervical disc displacement without myelopathy, and rotator cuff (capsule) sprain. Treatment to date has included home exercise program (HEP), left shoulder arthroscopy, right shoulder arthroscopy, and medication. Currently, the injured worker complains of right shoulder pain. The Primary Treating Physician's report dated March 16, 2015, noted the injured worker rated his pain a 5/10. Physical examination was noted to show decreased range of motion (ROM) of the right shoulder. The treatment plan was noted to include prescription of Lidoderm patches. The medication list includes Naproxen, Omeprazole Aleve and Orphenadrine. The patient's surgical history include repair of left middle and ring finger.

### 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 #30 2 refills:** Upheld

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

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

**Decision rationale:** Request: Lidocaine pad 5% day supply: 30 #30 2 refills. According to the MTUS Chronic Pain Guidelines regarding topical analgesics state that the use of topical analgesics is Largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. According to the MTUS Chronic Pain Guidelines Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri- cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. MTUS guidelines recommend topical analgesics for neuropathic pain only when trials of antidepressants and anticonvulsants have failed to relieve symptoms. Any trial of antidepressants and anticonvulsants for these symptoms were not specified in the records provided. Any intolerance or contraindication to oral medications is not specified in the records provided. Any evidence of post-herpetic neuralgia is not specified in the records provided. The medication Lidocaine pad 5% day supply: 30 #30 2 refills is not medically necessary and not fully established.