

Case Number:	CM15-0023177		
Date Assigned:	02/12/2015	Date of Injury:	05/19/2003
Decision Date:	03/26/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	02/06/2015

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: Utah, Arkansas
 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 66 year old female who sustained an industrial injury to the lower back on May 19, 2003. There was no mechanism of injury documented. A magnetic resonance imaging (MRI) on June 16, 2014 demonstrated desiccation of the lumbar disks and minimal broad-based bulge and facet hypertrophy. No evidence of significant neuroforaminal or central canal stenosis. The injured worker was diagnosed with lumbar facet arthralgia and left trochanteric bursitis. The injured worker underwent lumbar disk surgery (no date or procedure documented). According to the primary treating physician's progress report on December 3, 2014, the injured worker continues to experience low back pain and burning referring into the left hip and buttock. Straight leg raise is 90 degrees without referred pain and muscle strength of the bilateral extremities is within normal limits. Moderate pain and spasm on the left L4-5 and L5-S1 region were documented. Range of motion in all directions was completed with minimal pain. Current medications consist of Ibuprofen and topical analgesic. Current treatment modalities were not listed. The injured worker is Permanent & Stationary (P&S) and working full duty. The treating physician requested authorization for Lidoderm Patch 5% #90; Lidocaine 4% Gel to area, twice a day #1 x6 refills. On January 15, 2015 the Utilization Review denied certification for Lidoderm Patch 5% #90; Lidocaine 4% Gel to area, twice a day #1 x6 refills. Citations used in the decision process were the Medical Treatment Utilization Schedule (MTUS), Chronic Pain Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm Patch 5% #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Topical Analgesics

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine Patches Pages. 111-112..

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Lidoderm Patches MTUS guidelines state that Lidocaine may be used for peripheral pain, after there has been a trial of first-line therapy (such as tri-cyclic or SNRI antidepressants or AED such as Gabapentin or Lyrica) Topical lidocaine in the form of a patch has been designated for orphan status by the FDA for neuropathic pain. According to the clinical documentation provided and current MTUS guidelines; First line medications were not used previously to the Lidoderm. Therefore, Lidoderm Patch is not indicated as a medical necessity to the patient at this time.

Lidocaine 4% Gel apply Topically twice a day #1 x6 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 Lidocaine Patches Pages. 111-112..

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Lidoderm gel MTUS guidelines state that Lidocaine may be used for peripheral pain, after there has been a trial of first-line therapy (such as tri-cyclic or SNRI antidepressants or AED such as Gabapentin or Lyrica) Topical lidocaine in the form of a patch has been designated for orphan status by the FDA for neuropathic pain. According to the clinical documentation provided and current MTUS guidelines; First line medications were not used previously to the Lidoderm. Therefore, Lidoderm gel is not indicated as a medical necessity to the patient at this time.