

<b>Case Number:</b>	CM15-0034374		
<b>Date Assigned:</b>	03/02/2015	<b>Date of Injury:</b>	02/11/2008
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	01/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/23/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 33 year old male, who sustained an industrial injury on 02/11/2008. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. Diagnoses include status post bilateral sacroiliac joint radiofrequency nerve ablation, bilateral sacroiliac joint pain, bilateral lumbar three to four lumbar facet joint pain, lumbar facet joint arthropathy, status post lumbar three to four artificial disc replacement and lumbar four to sacral one fusion, lumbar sprain/strain, and depression secondary to chronic low back pain. Treatment to date has included medication regimen, status post lumbar three to four artificial disc replacement and lumbar four to sacral one fusion on 02/23/2011, status post sacroiliac joint injection, status post medial branch block of the bilateral lumbar three to four joints, and status post bilateral sacroiliac joint radiofrequency nerve ablation. In a progress note dated 01/13/2015 the treating provider reports complaints of low back pain. The treating physician requested Lidoderm Patch for neuropathic pain. On 01/23/2015 Utilization Review non-certified the requested treatment Lidoderm (Lidocaine Patch 5%) apply one patch twelve hours on and twelve hours off for a quantity of 30 with 2 refills, noting the California Medical Treatment Utilization Schedule, Chronic Pain Medical Treatment Guidelines, pages 1 to 127.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm patch apply 1 patch 12 hours on/12 hours off, #30, 2 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical lidocaine Page(s): 56-57, 112. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Lidoderm.

**Decision rationale:** The patient presents with low back pain. The request is for LIDODERM PATCH APPLY 1PATCH 12 HOURS ON, 12 HOURS OFF, #30 WITH 2 REFILLS. The patient is s/p several lumbar surgeries including L4-S1 fusion on 02/23/11 and bilateral sacroiliac joint radiofrequency nerve ablation. Per 01/13/15 progress report, the patient is currently taking Motrin, Trazodone, Voltaren Gel and Lidoderm patch. The patient is currently working. MTUS guidelines page 57 states, "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)." MTUS Page 112 also states, "Lidocaine Indication: Neuropathic pain Recommended for localized peripheral pain." When reading ODG guidelines, it specifies that lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. In this case, this patient started utilizing Lidoderm patches prior to 01/13/15. None of the reports discuss how Lidoderm patches have been used with what efficacy. Although the treater requested Lidoderm patch for neuropathic pain, there is no documentation that the patient has localized neuropathic pain, as required by MTUS guidelines. Therefore, the request IS NOT medically necessary.