

<b>Case Number:</b>	CM15-0082837		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	12/31/2005
<b>Decision Date:</b>	06/16/2015	<b>UR Denial Date:</b>	04/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2015

### 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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

### 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 (IW) is a 54-year-old male who sustained an industrial injury on 12/31/2005. Diagnoses include right sacroiliac joint dysfunction and status post L3 through S1 fusion. Treatment to date has included medications, TENS unit and spinal surgery. Diagnostics included an MRI. According to the progress notes dated 3/31/15, the IW reported ongoing axial low back pain; he related that his pain medications were helping with pain and helping him maintain function. He rated his pain 6/10, but stated with medications, his pain goes down to 5/10 and then up to 10/10 before he takes more pain medication. On examination, there was tenderness to palpation at the iliac crest level, straight leg raise and Yeoman's maneuver were negative bilaterally and Patrick's maneuver was positive bilaterally. A request was made for Lidoderm (Lidocaine patch 5%) x 30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm patch 5%, unknown quantity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 112 of 127.

**Decision rationale:** Regarding request for topical lidoderm, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the first line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Additionally, there is no documentation of analgesic effect or objective functional improvement because of the currently prescribed lidoderm. Finally, there is no documentation of localized peripheral pain as recommended by guidelines. As such, the currently requested lidoderm is not medically necessary.