

<b>Case Number:</b>	CM15-0238760		
<b>Date Assigned:</b>	12/15/2015	<b>Date of Injury:</b>	01/17/2013
<b>Decision Date:</b>	01/19/2016	<b>UR Denial Date:</b>	11/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/07/2015

### 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: North Carolina  
 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 (IW) is a 65 year old female, who sustained an industrial injury on 1-17-2013. The injured worker is being treated for bilateral shoulder arthrofibrosis, right cuff tendinosis, history of left shoulder labrum tear and bilateral shoulder pain. Treatment to date has included surgical intervention (right shoulder 8-09-2013), post-op physical therapy, medications and diagnostics. Per the Primary Treating Physician's Progress Report dated 10-02-2015, the injured worker presented for reevaluation of bilateral shoulders. She reported the severity of her pain as 4 out of 10. The pain is described as dull and increases with movement and becomes sharp. Objective findings included tenderness on palpation of the right shoulder, the AC joint and the right anterior shoulder. There is no documentation of significant functional improvement in symptoms, increase in activities of daily living or decrease in pain level attributed to the current medications. Work status was modified. There is no documentation of a trial of oral medications prior to the request for Lidoderm patches. There is no documentation for the necessity of extended use of Mobic. The plan of care included and authorization was requested on 10-02-2015 for Tylenol ES #100, Mobic 7.5mg #60 and Lidoderm #1 box. On 11-05-2015, Utilization Review non-certified the request for Mobic 7.5mg #60 and Lidoderm #1 box.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm patches, #1 box:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Lidoderm (lidocaine patch), Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** The California Chronic Pain Medical Treatment Guidelines section on topical lidocaine states: Lidocaine Indication: Neuropathic pain. 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). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. This medication is recommended for localized peripheral pain. The patient does have peripheral pain in the form of cervical radiculopathy. However, the patient has no documented failure of all first line agents indicated for the treatment of neuropathic pain as outlined above. Therefore, criteria as set forth by the California MTUS as outlined above have not been met and the request is not medically necessary.

**Mobic 7.5mg, #60 with 2 refills:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Acetaminophen, NSAIDs (non-steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**Decision rationale:** The California Chronic Pain Medical Treatment Guidelines section on NSAID therapy states: Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) This medication is recommended for the shortest period of time and at the lowest dose possible. The dosing of this medication is within the California MTUS guideline recommendations. The definition of shortest period possible is not clearly defined in the California MTUS. Therefore, the request is medically necessary.