

<b>Case Number:</b>	CM15-0006913		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	06/07/2008
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	01/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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: Preventive Medicine, Occupational 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 is a 58 year old male who sustained a work related injury on June 7, 2008, after falling and hitting his head and left shoulder while working in a grocery store. He also complained of right shoulder pain, both wrists and right hip pain. Treatment included multiple surgeries, cortisone injections, ice therapy and a variety of medications. Diagnoses made were chronic pain, hip osteoarthritis, right hip bursitis, lumbar stenosis, migraine headaches and bilateral wrist pain and bilateral shoulder impingement. Oral medications include Suboxone, Lexapro, Gabapentin, Seroquel and Trazadone. Currently, the injured worker complains of increased head, neck, back, arms, legs and hands pain and stiffness. On January 6, 2015, a request for a prescription of Lidoderm 5% patches #60 with refills times 5 was non-certified, noting the California MTUS Chronic pain Medical Treatment Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm 5% patches #60 with 5 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 Page(s): 111-113.

**Decision rationale:** MTUS Guidelines are very specific in stating the topical Lidoderm is only indicated for localized peripheral neuropathic pain. This patient's diagnosis(s) does not meet the Guideline criteria to support the use of Lidoderm. The shoulder, hip, and upper extremity pain are not documented to have a major neuropathic component that is limited in area. Under these circumstances the use of Lidoderm is not supported by Guidelines and the Lidoderm 5% patches #60 with 5 refills is not medically necessary.