MAXIMUS Federal Services

Case Number:	CM15-0009670		
Date Assigned:	01/27/2015	Date of Injury:	11/03/2011
Decision Date:	07/21/2015	UR Denial Date:	12/29/2014
Priority:	Standard	Application Received:	01/16/2015

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: Maryland
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 65-year-old female who sustained an industrial injury on 11/03/2011. Diagnoses include chronic lumbar back pain from an L5-S1 disc bulge and chronic right knee sprain. Treatment to date has included medications and cortisone injection to the right knee. MRI of the lumbar spine from 7/26/12 was noted to show a right paracentral disc bulge at the L5-S1 level without impingement on the right side at L5. MRI of the right knee dated 7/26/12 noted moderate degenerative disease involving the medial compartment. Electrodiagnostic testing of the bilateral lower extremities on 8/15/13 found no evidence of acute or chronic neuromyopathy. According to the progress notes dated 9/16/14, no specific subjective information was documented; the IW and the provider discussed a previous-filled prescription. On examination, there was right knee tenderness and swelling. McMurray's and Lachman's tests were negative on the right knee. Paralumbar tenderness was present from L2 to L5-S1 and to the right sacroiliac joint and right trochanter. Lumbar range of motion was reduced. The provider stated a tricyclic antidepressant, Amitriptyline, was previously trialed. A request was made for a prescription for Lidoderm patch 5%.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patch 5%: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56.

Decision rationale: Lidoderm Patch 5% is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines The guidelines state that 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). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. The documentation does not indicate failure of first line therapy for peripheral pain. The documentation does not indicate a diagnosis of post herpetic neuralgia. The documentation does not indicate functional improvement from Lidocaine. Furthermore, the request does not specify a quantity. For these reasons, the request for Lidoderm Patch 5% is not medically necessary.