

<b>Case Number:</b>	CM15-0121987		
<b>Date Assigned:</b>	07/06/2015	<b>Date of Injury:</b>	05/23/1988
<b>Decision Date:</b>	08/04/2015	<b>UR Denial Date:</b>	05/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/24/2015

### 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, Pain Management

### 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 60 year old male, who sustained an industrial injury on May 23, 1988. Treatment to date has included cervical fusion and medications. Currently, the injured worker complains of neck pain and upper extremity symptoms. He reports that 30 tablets of tramadol lasted for one year. He reports that his pain level is rated a 3 at the time of evaluation. On physical examination the injured worker had no significant tenderness to palpation over the cervical spine but did have muscular tightness over the upper trapezius. The diagnoses associated with the request include cervicalgia and carpal tunnel syndrome. The treatment plan includes Lidoderm patches #90 5%.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm patches 5% quantity 90 with three refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 112 of 127.

**Decision rationale:** Regarding request for 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 1st 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 localized peripheral neuropathic pain and failure of first-line therapy. As such, the currently requested Lidoderm is not medically necessary.