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| <b>Case Number:</b>   | CM15-0021312 |                              |            |
| <b>Date Assigned:</b> | 02/10/2015   | <b>Date of Injury:</b>       | 10/23/2007 |
| <b>Decision Date:</b> | 04/14/2015   | <b>UR Denial Date:</b>       | 01/12/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/04/2015 |

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, 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 is a 57-year-old female, who sustained an industrial injury on 10/23/2007. She has reported subsequent back pain and was diagnosed with lumbar disc disorder, degenerative disc disease of the lumbar spine, lumbosacral spondylosis and sprain/strain of the sacroiliac. Treatment to date has included oral and topical pain medication, TENS unit, H wave unit and lumbar epidural steroid injection. In a progress note dated 10/16/2014, the injured worker complained of constant low back pain that was rated as a 7/10 with medication and 10/10 without medication. Objective findings were notable for tenderness of the lumbar paravertebral regions and the left sacroiliac joint at the L4-L5 and L5-S1, decreased range of motion and diminished sensation in the right lower extremity. A request for authorization of Lidoderm patch was made.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm 5% (700 mg/patch) #30 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): (s) 111-112.

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

**Decision rationale:** According to MTUS guidelines, Lidoderm is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. 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). In this case, there is no documentation that the patient developed neuropathic pain that did not respond to first line therapy and the need for Lidoderm patch is unclear. There is no documentation of efficacy of previous use of Lidoderm patch. Therefore, the prescription of Lidoderm 5% (700 mg/patch) #30 with 1 refill is not medically necessary.