

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

[REDACTED]

Dated: 12/17/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 8/1/2013  
Date of Injury: 9/13/2005  
IMR Application Received: 8/15/2013  
MAXIMUS Case Number: CM13-0011714

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations, [REDACTED]  
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## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma and Texas. 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 physician 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/services.

### DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:



### CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 68-year-old who reported a work-related injury on 08/13/2005, specific mechanism of injury not stated. Subsequently, the patient presents for treatment of the following diagnoses, cervical strain superimposed upon cervical degenerative changes and 2 mm bulges at C3-4, C4-5, and C5-6, headaches aggravated by cervical strain, chronic neck and head pain, constipation related to opioid analgesic pain management, and opioid pain management. Clinical note dated 08/28/2013 reports the patient was seen for followup under the care of Dr. [REDACTED]. The provider documents the patient utilizes the following medication regimen for his chronic pain complaints: OxyContin 10 mg by mouth twice a day, oxycodone 5 mg daily, Celebrex 200 mg daily, Lidoderm patch daily as needed, topical analgesic 4 times a day, Percodan 4.34/325 daily as needed, Frova 2.5 mg daily as needed, baclofen 20 mg half tablet daily as needed, Docusate 250 mg daily, and Pennsaid solution 3 times a day. The provider documents the patient recently completed a course of physical therapy and was approved for Botox injections for his pain complaints. However, the patient is fearful and prefers opioid analgesic medication. The provider documented upon physical exam of the patient, motor strength was noted to be 5/5 throughout with sensation noted to be at 4/5 to the left C6-7 dermatomal distribution in the left upper extremity.

### IMR DECISION(S) AND RATIONALE(S)

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

**1. Error! Reference source not found. is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 56 - 57, which is part of the MTUS.

According to the Chronic Pain Medical Treatment Guidelines, Lidoderm patches are not a first-line treatment and are only FDA approved for postherpetic neuralgia. The current request previously received an adverse determination due to a lack of California MTUS Guidelines support of utilization of this transdermal analgesic without documentation evidencing, “topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy, tricyclic or SNRI (serotonin and noradrenaline reuptake inhibitor) antidepressants or an AED (antiepileptic drug), such as gabapentin or Lyrica.” The clinical notes fail to evidence the patient had failed with oral anti-epileptic medications for his neuropathic pain complaints. **The request for one prescription of Lidoderm 5% #30 is not medically necessary or appropriate.**

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient’s physician. MAXIMUS is not liable for any consequences arising from these decisions.