

Case Number:	CM15-0167413		
Date Assigned:	09/08/2015	Date of Injury:	02/09/2004
Decision Date:	10/13/2015	UR Denial Date:	08/03/2015
Priority:	Standard	Application Received:	08/25/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 61-year-old male, who sustained an industrial injury on February 9, 2004. He reported head injury, bilateral upper extremity pain, shoulder, spine, neck, low back, face and leg pain after a catastrophic accident when "250 ton" crushed him. The injured worker was diagnosed as having crush injury to multiple body parts, traumatic brain injury, recurrent DVT, cavitory lesion of the lung, status post cervical spinal fusion, postphlebic syndrome, major depression and late effects of a traumatic injury. Treatment to date has included diagnostic studies, radiographic imaging, surgical intervention of the cervical spine, medications and work restrictions. Currently, the injured worker continues to report right shoulder pain, lumbar spine pain, right hip pain, right lower extremity pain, numbness in tingling in the bilateral upper and lower extremities, diplopia, tendency to "freeze up and become angry", flashbacks, limited stress tolerance, depression, poor appetite, social isolation, claustrophobia and loss of interest in sexual intercourse per the AME psychiatric report on May 18, 2015. The injured worker reported an industrial injury in 2004, resulting in the above noted pain. He was treated surgically without complete resolution of the pain. Evaluation on June 6, 2015, revealed no physical examination, diagnoses or list of medications. Evaluation on June 16, 2015, revealed no assessment information. The supplemental report on July 28, 2015, revealed the physician believed the injured worker would need constant supervision. The RFA included requests for Lidocaine 5% patch and was non-certified on the utilization review (UR) on August 3, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidocaine 5% patch: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The California chronic pain medical treatment guidelines section on topical lidocaine states: Lidocaine Indication: Neuropathic pain 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). The FDA for neuropathic pain has designated topical lidocaine, in the formulation of a dermal patch (Lidoderm) for orphan status. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Non-dermal patch formulations are generally indicated as local anesthetics and anti-pruritics. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007, the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. (Argoff, 2006) (Dworkin, 2007) (Khaliq-Cochrane, 2007) (Knotkova, 2007) (Lexi-Comp, 2008) Non-neuropathic pain: Not recommended. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. (Scudds, 1995) This medication is recommended for localized peripheral pain. The patient has no documented failure of all first line agents indicated for the treatment of neuropathic pain as outlined above. Therefore, criteria as set forth by the California MTUS as outlined above have not been met and the request is not medically necessary.