MAXIMUS Federal Services

| Case Number: | CM15-0056041 | | |
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| Date Assigned: | 04/15/2015 | Date of Injury: | 06/07/2000 |
| Decision Date: | 06/17/2015 | UR Denial Date: | 02/24/2015 |
| Priority: | Standard | Application Received: | 03/24/2015 |

## 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: New York, Tennessee
Certification(s)/Specialty: Emergency 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 54-year-old female who sustained an industrial injury on 06/07/2000. Diagnoses include chronic pain syndrome, epidural fibrosis, status post lumbar fusion, spondylolisthesis L4-5; status post spinal cord stimulator implantation with subsequent removal on 01/05/2015, urological diagnosis, right shoulder impingement syndrome, and contusion bilateral knees, status post falls secondary to leg giving way. Treatment to date has included diagnostic studies, medications, and Percutaneous Tibial Nerve Stimulation. A physician progress note dated 01/22/2015 documents the injured worker has continued low back pain radiating to her legs. She also notes her legs give way frequently and she has fallen, especially with housekeeping duties such as laundry. She ambulates with the use of a cane. There is tenderness in the lower lumbar paravertebral musculature. Forward flexion is to 30 degrees, extension to neutral. The treatment plan is for home health services to assist with housekeeping and home health assistance due to falls. Treatment requested is for Home Health Care Assistance 4 hours per day/7 days per week, and Lidoderm patches #30 refills x 2.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidoderm patches #30 refill x 2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 112. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain Lidoderm® (lidocaine patch).

**Decision rationale:** Lidocaine is recommended for localized peripheral pain after the evidence of a trial for first-line therapy, such as an antidepressant or antiepileptic drug. It is only FDA approved for the treatment of post-herpetic neuralgia. The guidelines state that further research is needed to recommend this treatment for chronic neuropathic pain. Criteria for use of Lidoderm patches: (a) Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. (b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). (c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. (d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non- neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale. (e) The area for treatment should be designated as well as number of planned. (f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks). (g) It is generally recommended that no other medication changes be made during the trial period. (h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued. (i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued. In this case there is no documentation that the patient has failed therapy with antidepressants. Criteria for lidoderm patches have not been met. The request should not be authorized. Therefore, the requested medical treatment is not medically necessary.

**Home Health Care Assistance 4 hours per day/7 days per week:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 51.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state that home health services are recommended only for recommended medical treatment in patients who are homebound, on a part-time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include personal care like bathing, dressing, or toileting and it does not include homemaker services like shopping, laundry, or cleaning. The care requested in this case included laundry. This service is not covered. The request should not be authorized. Therefore, the requested medical treatment is not medically necessary.