

Case Number:	CM15-0058360		
Date Assigned:	04/03/2015	Date of Injury:	12/25/1998
Decision Date:	05/04/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/27/2015

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 67 year old male, who sustained an industrial injury on 12/25/1998 reporting low back pain. On provider visit dated 01/02/2015 the injured worker has reported lumbar spine pain. On examination of the lumbar spine noted tenderness and muscle spasm, straight leg raise positive. The diagnoses have included history of lumbar spine surgery x3, lumbar fusion and status post left elbow surgery. Treatment to date has included pool therapy and pain medication. The provider requested to start Lidoderm patch 5% quantity 60 for pain management and Home Care Assistance, 24 hours a day, 7 days a week, for 1 year to assist with cooking, cleaning and etc.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patch 5% quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113.

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). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. 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 a diagnosis of lumbar disc disease but no 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.

Home Care Assistance, 24 hours a day, 7 days a week, for 1 year: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 92; 51. Decision based on Non-MTUS Citation Blue Cross Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines home health care Page(s): 51.

Decision rationale: The California MTUS section on home health care states: Recommended only for otherwise recommended medical treatment for 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 homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. (CMS, 2004) The request is for 24 hour care for 7 days a week. This is in excess of recommendations and therefore the request is not medically necessary.