MAXIMUS Federal Services

Case Number:	CM15-0048364		
Date Assigned:	03/20/2015	Date of Injury:	10/26/2009
Decision Date:	05/01/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	03/13/2015

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: District of Columbia, Virginia
Certification(s)/Specialty: Internal 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 38 year old male who sustained an industrial injury on 10/26/09 when he tripped and twisted his left knee and back. He had 2 arthroscopic surgeries, the first providing no relief and the second with minimal benefit, and has lumbar disc disease. He developed hypertension and was told to lose weight. He currently complains of intermittent left hip and constant left knee pain with radiation down to the foot. The radiation started after the steroid injection. There is a popping sensation in the left knee. The left hip pain radiates from the low back. The pain intensity is 3-4/10. Medications and cream temporarily relieve the pain. Medications include nortripptyline, nabumetone, Ketoprofen and LidoPro creams and over the counter cream. Diagnoses include lumbar disc displacement, internal derangement of the knee, obesity, left L5-S1 radiculoapthy, left sacroiliac joint dysfunction, status post left knee arthroscopic surgery (2011 and 2012), chronic neck pain and herniated nucleus propulsus of the lumbar spine. Treatments to date include epidural steroid injection (10/7/14) with 50% improvement; medications offering temporary relief; orthovisc injection to the left knee with some benefit; chiropractic therapy with no benefit; physical therapy with little benefit; left knee brace and acupuncture. Diagnostics include electromyography/ nerve conduction study of the bilateral lower extremities (4/25/13) abnormal; MRI of the pelvis (5/3/14, 3/3/14) unremarkable; MRI of the left knee (5/3/14) abnormal; MRI of the lumbar spine (6/10/13). In the progress note dated 1/21/15 the treating provider's plan of care indicates to continue with LidoPro topical analgesic as it provides some temporary relief.

IMR ISSUES, DECISIONS AND RATIONALES

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

LidoPro Topical Ointment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792 Page(s): 111-112.

Decision rationale: Per MTUS: Topical Analgesics Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. [Note: Topical analgesics work locally underneath the skin where they are applied. These do not include transdermal analgesics that are systemic agents entering the body through a transdermal means. See Duragesic (fentanyl transdermal system).] 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)Per review of the clinical documentation

provided and cited guidelines, lidocaine patches would be the formulation of topical usage which would be approved. Therefore, this request is not medically necessary.