

<b>Case Number:</b>	CM13-0029348		
<b>Date Assigned:</b>	11/01/2013	<b>Date of Injury:</b>	08/15/2007
<b>Decision Date:</b>	08/28/2014	<b>UR Denial Date:</b>	09/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/26/2013

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

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

This is a 56-year-old female with an 8/15/07 date of injury. The patient was injured performing her usual and customary duties throughout the course of her employment as a food service worker. According to an initial orthopedic consultation exam report, the patient complained that her hands were constantly numb and she cannot feel items. Her bilateral shoulders felt tired with overhead use and had pain with range of motion. She felt her number one complaint was her lower back, followed by her hands, followed by her neck and shoulders. Objective findings include: decreased sharp-dull discrimination over the bilateral radial digits, positive Tinel's in the carpal tunnel, positive Phalen's, bilateral elbow range of motion (ROM) is 0-145, multiple trigger points along the trapezius, and local paracervical pain with Spurling maneuver. Diagnostic impressions include: bilateral carpal tunnel syndrome, bilateral shoulder tendonitis, painful neck-lower back, and right volar ganglion cyst. Treatment to date includes: medication management, activity modification, and chiropractic treatment. A UR decision dated 9/19/13 denied the requests for Omeprazole, Terocin, Synovacin, and Tramadol.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**OMEPRAZOLE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Omeprazole).

**Decision rationale:** MTUS and the FDA support proton pump inhibitors in the treatment of patients with GI disorders such as gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic nonsteroidal anti-inflammatory drug (NSAID) therapy. In the records reviewed, there is documentation that the patient is utilizing the NSAID, Diclofenac. Guidelines support the use of Omeprazole in patients on chronic NSAID therapy. However, the strength and quantity of the medication were not specified in this request. Therefore, the request as submitted, is not medically necessary.

**TEROCIN:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57, 112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation [www.dailymed.nlm.nih.gov](http://www.dailymed.nlm.nih.gov).

**Decision rationale:** Terocin is a topical pain relief lotion containing Methyl Salicylate 25%, Capsaicin 0.025%, Menthol 10%, and Lidocaine 2.50%. MTUS Chronic Pain Medical Treatment Guidelines do not recommend compound medications including Lidocaine (in creams, lotion or gels), for topical applications. In addition, CA MTUS states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended for use. MTUS Chronic Pain Medical Treatment Guidelines state that topical Lidocaine in the formulation of a dermal patch has been designated for orphans status by the FDA for neuropathic pain. In addition, MTUS Guidelines state that topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. It is unclear whether the provider is requesting the lotion formulation or the patch formulation. In the records reviewed, there is documentation that the patient is utilizing Terocin lotion and Lidocaine patches. In addition, there is no documentation that the patient has had a trial of a first-line therapy product in order for the medical necessity of Lidocaine patch to be considered. Lidocaine in a topical cream/lotion/ointment formulation is not supported by guidelines, and is therefore not medically necessary.

**SYNOVACIN:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.physiciansproducts.net/joomla/index.php/nutraceuticals/87-synovacin>.

**Decision rationale:** MTUS states that Glucosamine and Chondroitin Sulfate are recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. In the reports provided for review, there is no documentation of a diagnosis of arthritis. In addition, the strength and quantity of this medication requested were not provided in this request. Therefore, the request is not medically necessary.

**TRAMADOL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In the reports reviewed, there is no documentation of significant pain reduction or improved activities of daily living. In addition, there is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, urine drug screen, or Controlled Substance Utilization Review and Evaluation System (CURES) monitoring. The strength, quantity, and frequency of use for this medication was not provided in this request. Therefore, the request is not medically necessary.