

<b>Case Number:</b>	CM13-0043547		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	03/27/2012
<b>Decision Date:</b>	02/20/2014	<b>UR Denial Date:</b>	10/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/24/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular and is licensed to practice in Maryland. 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 physician 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 31 year old female with a date of injury of 03/27/2012. The body parts covered under this condition is right wrist and hand, although she has another claim as well involving her neck. Her diagnosis include: 1. Wrist joint inflammation with evidence of regional reflex sympathetic dystrophy, but with MRI missing. 2. Element of depression she has last worked on the date of this injury. She has had treatment including but not limited to physical therapy, medications, TENS (Transcutaneous Electrical Nerve Stimulation). Cervical MRI: Date of Exam: 9/27/2012 reveals: 1. Broad-based central disc protrusion at C3-C4 measuring 1-2 mm. 2. Disc bulge at C4-C5 measuring 1 mm. 3. Disc bulge at C5-C6 measuring 1 mm. 9/26/12. EMG of the BUE: Normal study with no electro diagnostic evidence of median, ulnar mononeuropathy across the wrist or elbow consistent with carpal tunnel or cubital tunnel syndrome. No evidence of suggestive cervical radiculopathy or plexopathy 10/26/13 MRI of R wrist: IMPRESSION: 1. Mild diffuse synovitis and joint effusion. 2. Mild dorsal subluxation of the distal ulna. 10/5/12 treatment plan by [REDACTED]: TREATMENT PLAN: The patient was given a prescription today includes Vicodin ES, #90. She did not receive any other medication at this time. She will continue with hot and cold, TENS (Transcutaneous Electrical Nerve Stimulation) and braces as needed. This is also a prospective request for medications at next visit, Vicodin ES, #90 for moderate-to-severe pain and Flexeril 7.5 mg, #60 for muscle spasm, Dendracin 120 mL for topical cream use and Motrin 600 mg, #90 for inflammation. The patient is not currently working and she should avoid forceful pushing, pulling, lifting, and grabbing and repetitive use of the right upper extremity. She has a follow-up visit scheduled in four weeks 10/2/13 SUBJECTIVE COMPLAINTS: The coverage is for the right wrist and hand. The patient has avoided all injections. The MRI of the wrist has been approved

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol Extended Release 150mg, Qty 10.00:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79, 80, 82, 84..

**Decision rationale:** Tramadol ER 150mg, Qty 10.00 is not medically necessary per Chronic Pain Medical Treatment Guidelines. Per the Chronic Pain Medical Treatment Guidelines regarding Tramadol: There are no long term studies to allow for recommendations for longer than three months (Cepeda, 2006). At this point patient has exceeded the 3 month recommended limit for remaining on Tramadol and therefore this is not medically necessary.

**Terocin Patches:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56, 105, 111,112.

**Decision rationale:** Terocin patches are not medically necessary per Chronic Pain Medical Treatment Guidelines. A Terocin patch contains: Menthol 4%; Lidocaine 4%. Per Chronic Pain Medical Treatment Guidelines, "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. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia". Per Chronic Pain Medical Treatment Guidelines, "Topical Analgesics are 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. ." Additionally, the Chronic Pain Medical Treatment Guidelines state, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Although Menthol is not specifically addressed in the Chronic Pain Medical Treatment Guidelines menthol is present in Ben Gay which is recommended by the Chronic Pain Medical Treatment Guidelines. Due to the fact that documentation submitted does not show evidence of failure of oral first line therapy for peripheral pain such as antidepressants or anticonvulsants, and that patient does not have post herpetic neuralgia and also due to the fact that per Chronic Pain Medical Treatment Guidelines, "Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia," Terocin patch is not medically necessary

**Lido Pro Cream 4oz:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56, 57,105,111, 112-113..

**Decision rationale:** LidoPro cream not medically necessary per Chronic Pain Medical Treatment Guidelines. Per guidelines, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Lidopro is a combination of Capsaicin 0.0325%; Lidocaine 4.5%; Menthol 10%; Methyl Salicylate 27.5%. Per Chronic Pain Medical Treatment Guidelines, "There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy." Furthermore, "Topical lidocaine may be 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 orLyrica)." There is no evidence patient has tried the above mentioned first line therapy medications. In addition, there is little to no research to support the use of many of these agents. For these reasons, LidoPro cream is not medically necessary.