

Case Number:	CM14-0166778		
Date Assigned:	10/14/2014	Date of Injury:	06/24/2009
Decision Date:	11/24/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/09/2014

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 Emergency Medicine and is licensed to practice in California. 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:

The injured worker is a 48-year-old male who reported an injury on 06/24/2009 due to an unknown mechanism. The diagnosis was distal ulnar fracture, status post arthrotomy, capsulectomy, and synovectomy in 2011; the second surgery, the injured worker had partial ostectomy of the ulnar and capsulectomy in 2013; and chronic pain syndrome. The physical examination dated 08/28/2014 revealed that the injured worker was 6 weeks from ulnar excision, tenolysis, and tenodesis along the extensor carpi ulnaris. The injured worker had a cast on. The injured worker had not started therapy yet. The pain was reported to be a 6/10. It was reported that the injured worker uses a TENS unit. It was also reported that the injured worker was not sleeping at night and ended up taking naps during the day. Medications were Norco, Flexeril, Naproxen, Tramadol, Protonix, Trazodone, Terocin patches, and LidoPro cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin Patches #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylates, Topical Analgesics, Lidocaine Page(s): 105,111, 112.

Decision rationale: The decision for Terocin patches #30 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulation of lidocaine (whether creams, lotions, or gels) is indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. Per DailyMed.nlm.nih.gov, Terocin patches are topical lidocaine and menthol. The efficacy of this medication was not reported. There is a lack of documentation of objective functional improvement from the use of this medication. Also, the request does not indicate a frequency for the medication. The medical guidelines do not support the use of compounded topical analgesics and state that they are largely experimental in use. Continued use of this medication would not be supported. Therefore, this request Terocin Patches #30 is not medically necessary.

LidoPro Cream #1 bottle: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylate, Topical Analgesic, Topical Capsaicin, Lidocaine Page(s): 105, 111, 28, 112.

Decision rationale: The decision for LidoPro cream #1 bottle is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. 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. The guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulation of lidocaine (whether creams, lotions, or gels) is indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. Per Drugs.com, LidoPro is a topical analgesic containing capsaicin/lidocaine/menthol/methyl salicylate. The efficacy of this medication was not reported. It also was not indicated where the injured worker was to apply this medication. This medication contains capsaicin. The medical guidelines state that capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Also, the request does not indicate a frequency for the medication. There is a lack of documentation of an

objective assessment of the injured worker's pain. Therefore, this request LidoPro Cream #1 bottle is not medically necessary.

Protonix 20mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

Decision rationale: The decision for Protonix 20 mg #60 is not medically necessary. The California Medical Treatment Utilization Schedule recommends clinicians to determine if the patient is at risk for gastrointestinal events which include age > 65 years, a history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant; or using a high dose/multiple NSAIDs. Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., Ibuprofen, Naproxen, etc.) Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (proton pump inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a COX 2 selective agent. Long term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Patients at high risk for gastrointestinal events with no cardiovascular disease: A COX 2 selective agent plus a PPI if absolutely necessary. The efficacy of this medication was not reported. There were no reports or diagnosis of gastrointestinal events. Also, the request does not indicate a frequency for the medication. There is a lack of documentation indicating why this medication is necessary. Therefore, the request for Protonix 20mg #60 is not medically necessary.