

<b>Case Number:</b>	CM14-0036470		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	04/22/1994
<b>Decision Date:</b>	08/15/2014	<b>UR Denial Date:</b>	02/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/25/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 65-year-old female who reported an injury on 04/22/1994. The mechanism of injury was not provided in the medical records. Her current diagnoses included chronic low back pain, lumbar degenerative disc disease, and sacroiliac joint dysfunction. Her previous treatments included medications. Within the most recent clinical note dated 02/04/2014, the injured worker had complaints of constant low back pain rated at a 9-10/10. She reported she had used Vicodin and Percocet in the past to control pain; however, they upset her stomach and she felt ill after consuming them. She reported she was currently not using narcotics for pain and she used hot and cold packs as needed. Pain was worse with movement. There was complaints of right shoulder pain rated at a 10/10 which had began 2 weeks ago and the pain prevents her from raising her right arm above shoulder level. On physical examination of the lumbar spine the physician reported extension was 15 degrees and flexion 30 degrees. Her right upper extremity abducts to 45 degrees due to pain. The current request is for Voltaren gel 1% 100 grams 3 bottles quantity 3, Lidopro lotion 4 ounces quantity 1 and Terocin patches #30 quantity 30. The rationale for the request was for pain relief. The Request for Authorization was provided on 02/05/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren gel 1% 100g 3 bottles QTY: 3.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, page(s) 111-113 Page(s): 111-113.

**Decision rationale:** The California MTUS Chronic Pain Medical Treatment Guidelines state there is little evidence to use topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. Voltaren gel is recommended for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). Per the clinical documentation provided, it indicated the injured worker continued to have chronic pain in his the low back and right shoulder at 9-10/10. The guidelines state there was little evidence to use topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. The request as submitted failed to provide the frequency of the medication. As such, the request for Voltaren gel 1% 100 grams 3 bottles quantity 3 is not medically necessary and appropriate.

**LidoPro lotion 4oz QTY: 1.00:** 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 Page(s): 111-113.

**Decision rationale:** The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also indicate that 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 of other treatments. Lidocaine is only recommended in the form of the Lidoderm patch and no other commercial approved topical formulation of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. Although the clinical documentation provided indicated the patient continued to have chronic low back pain and shoulder pain and had failed other treatments; there was no indication that the patient had neuropathic pain. As the request for Lidopro lotion contains lidocaine of which is not approved for topical formulation except as a Lidoderm Patch, the request would not be supported. The request also failed to provide the location the medication was to be applied and the frequency. As such, the request for Lidopro lotion 4 ounces quantity 1 is not medically necessary and appropriate.

**Terocin patches #30 QTY: 30.00:** Upheld

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

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

**Decision rationale:** The California MTUS 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 state that lidocaine is only recommended in the form of the Lidoderm patch and no other commercial approved topical formulations of lidocaine whether creams, lotions, or gels are indicated for neuropathic pain. As the clinical documentation provided indicated the patient continued to have chronic low back pain and shoulder pain and had failed other treatments; there was no indication that the patient had neuropathic pain. As the requested compound contains lidocaine which is not approved for topical formulation except as a Lidoderm Patch, the request would not be supported. The request also failed to provide the location the medication was to be applied and the frequency. As such, the request for decision for Terocin patches #30 quantity 30 is not medically necessary and appropriate.