

<b>Case Number:</b>	CM14-0056515		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	08/20/2012
<b>Decision Date:</b>	09/05/2014	<b>UR Denial Date:</b>	04/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/26/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 51-year-old male who reported an injury on 07/09/2013 due to an unknown mechanism. The injured worker was diagnosed with a double bone forearm fracture to the right forearm. The injured worker previously underwent a right forearm open reduction and internal fixation (ORIF). On 04/11/2014 an X-ray to the right forearm was performed with no acute fracture identified, the prior ORIF of the proximal third shaft fractures of the ulna and radius were visualized, and joint spaces were well maintained and alignment and mineralization were normal. On 10/25/2013 an electromyography (EMG) and a nerve conduction velocity (NCV) were performed, which revealed abnormal findings. On 04/11/2014 the injured worker presented with a complaint of right forearm pain on the medial side with numbness since his injury. The examining physician noted the injured worker reported complaints of pain and the injured worker was status post ORIF. The Request for Authorization form and rationale were not presented for review with these documents.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lidopro121g:** 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 Analgesics Page(s): 111-113.

**Decision rationale:** LidoPro is comprised of Capsaicin 0.0325%, Lidocaine, Menthol, and Methyl Salicylate. The MTUS Guidelines note topical analgesics 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 for use. The guidelines recommend the use of Capsaicin only as an option in patients who have not responded or are intolerant to other treatments for patients with osteoarthritis, postherpetic neuralgia, diabetic neuropathy, and post mastectomy pain. The guidelines note topical Lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain and no other commercially approved topical formulations of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. There is no indication that the injured worker has a diagnosis of neuropathic pain. There is no documentation indicating trials of antidepressants and anticonvulsants were done prior to the request for a topical compound. There is a lack of documentation indicating the injured worker has not responded to or was intolerant of other treatments. The medication contains Lidocaine in a cream form, which is not recommended per the guidelines. As such, the request is not medically necessary.

**Omeprazole 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, GI Symptoms and Cardiovascular Risk Page(s): 68.

**Decision rationale:** MTUS Guidelines recommend the use of a proton pump inhibitor (such as Omeprazole) for injured workers at intermediate risk for gastrointestinal events with no cardiovascular disease and injured workers at high risk for gastrointestinal events with no cardiovascular disease. The guidelines note injured workers at risk for gastrointestinal events include injured workers over 65 years of age, injured workers with a history of peptic ulcer, GI bleeding or perforation, with concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAIDs. The physician notes the injured worker is not over the age of 65. There is no documentation of a history of a peptic ulcer, gastrointestinal bleeding or perforation. The injured worker reported no adverse effects from medications including episodes of gastrointestinal events. There is no documentation indicating the injured worker is currently prescribed aspirin, corticosteroids, anticoagulants or high dose or multiple NSAIDs. The requesting physician's rationale for the request is not indicated within the provided documentation. There is no evidence of gastrointestinal issues within the documentation. There is a lack of documentation indicating the injured worker has significant objective improvement with the medication. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. As such, the request is not medically necessary.

**Ibuprofen 800mg #100:** 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 (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

**Decision rationale:** MTUS Guidelines recommend the use of NSAIDs for patients with osteoarthritis (including knee and hip) and patients with acute exacerbations of chronic low back pain. The guidelines recommended NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy in patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. In patients with acute exacerbations of chronic low back pain, the guidelines recommend NSAIDs as an option for short-term symptomatic relief. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. An adequate and complete pain assessment is not provided within the medical records. There is a lack of documentation indicating how long the injured worker has been prescribed this medication. The lack of documentation regarding the nature and degree of pain, history of the use of this medication, along with a list of current prescriptions makes it difficult to determine the efficacy of this medication regarding pain reduction and functional improvement. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. As such, the request is not medically necessary.

**TENS x4 electrodes:** 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 Criteria for the Use of TENS Page(s): 114-116.

**Decision rationale:** MTUS Guidelines note TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The guidelines recommend the use of electrical stimulation for patients with neuropathic pain, complex regional pain syndrome (CRPS) II, phantom limb pain, spasticity, and multiple sclerosis. The guidelines note there should be documentation of chronic intractable pain of at least three months duration with evidence that other appropriate pain modalities have been tried (including medication) and failed. The guidelines recommend a one-month home based trial of the TENS unit should be performed with documentation of how often the unit was used and outcomes in terms of pain relief and function. The physician has failed to document a 3 month period of chronic intractable pain. The physician has provided no evidence that other appropriate pain modalities have been tried, including medication, and failed. The physician is seeking to purchase this equipment; however, there is no documentation indicating the injured worker has

undergone a one month home based TENS trial with documentation of the frequency of use as well as increased function, decreased pain, and decreased medication usage. As such, the request is not medically necessary.