

Case Number:	CM15-0030599		
Date Assigned:	03/18/2015	Date of Injury:	01/09/1997
Decision Date:	05/08/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/18/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Family Practice

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 60-year-old female who reported an injury on 01/09/1997. The mechanism of injury was not provided. The diagnoses included left shoulder impingement, status post intervention with repeat MRI evidence of rotator cuff tear, discogenic cervical condition, and status post 4 level fusion with tightness and spasm. There was a Request for Authorization submitted for review dated 03/23/2015. The documentation of 03/05/2015 revealed the injured worker had numbness and tingling along the right elbow and arm. The mechanism of injury was not provided. The injured worker had utilized a TENS unit which was not working well. The injured worker was noted to have injections to the shoulder blade in 2013. The injured worker was utilizing Fioricet for headaches and had not gone to therapy. The objective findings revealed tenderness along the rotator cuff with weakness to resisted "function." The grip was effective and the impingement sign was positive. The treatment plan included Neurontin 600 mg #90, Protonix 20 mg #60, Flexeril 7.5 mg #60, Nalfon 400 mg #60, tramadol ER 150 mg. Additionally, the injured worker was utilizing lorazepam 1 mg #60 and Valium 5 mg #40. The injured worker was undergoing urine drug screens.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription for LidoPro lotion 40z: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals. Topical Analgesic. Topical Capsaicin. Lidocaine Page(s): 105,111, 28, 112. Decision based on Non-MTUS Citation www.drugs.com/search.php?searchterm=LidoPro.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Capsaicin: 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 (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are 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 clinical documentation submitted for review failed to provide documentation of a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation indicating a necessity for 2 topical products that contained lidocaine. There was a lack of documentation of objective functional benefit and an objective decrease in pain. The date for the request was not provided. The request as submitted failed to indicate the body part and the frequency for the treatment. Given the above, the request for 1 prescription for LidoPro lotion 40z is not medically necessary.

1 prescription for Terocin patches #20: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals. Topical Analgesic. Topical Capsaicin. Lidocaine Page(s): 105,111, 28, 112. Decision based on Non-MTUS Citation dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=100ceb76-8ebe-437b-a8de-37cc76ece9bb.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one 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 (tri-cyclic or SNRI anti-depressants or an AED

such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. Per dailymed.nlm.nih.gov, Terocin patches are topical Lidocaine and Menthol. The clinical documentation submitted for review failed to provide documentation of a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation indicating a necessity for 2 topical products that contained lidocaine. There was a lack of documentation of objective functional benefit and an objective decrease in pain. The date for the request was not provided. The request as submitted failed to indicate the body part and the frequency for the treatment. Given the above, the request for 1 prescription for Terocin patches #20 is not medically necessary.

1 cervical traction unit with air bladder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Traction (mechanical).

Decision rationale: The Official Disability Guidelines indicate a home cervical patient controlled traction unit may be appropriate for patients with radicular symptoms in conjunction with a home exercise program. The clinical documentation submitted for review failed to provide documentation the injured worker would be utilizing the unit with a home exercise program. Additionally, the request as submitted failed to indicate whether the unit was for rental or purchase. Given the above, the request for 1 cervical traction unit with air bladder is not medically necessary.

1 prescription for lorazepam 1mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The California Medical Treatment Utilization Guidelines do not recommend the use of benzodiazepines for longer than 4 weeks due to the possibility of psychological or physiological dependence. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Therefore, continued use would not be supported. The clinical documentation submitted for review failed to provide documentation of exceptional factors. The objective functional benefit was not provided. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating a necessity for 2 benzodiazepines. Given the above, the request for 1 prescription for lorazepam 1mg #60 is not medically necessary.

1 prescription for Valium 5mg #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 Benzodiazepines Page(s): 24.

Decision rationale: The California Medical Treatment Utilization Guidelines do not recommend the use of benzodiazepines for longer than 4 weeks due to the possibility of psychological or physiological dependence. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Therefore, continued use would not be supported. The clinical documentation submitted for review failed to provide documentation of exceptional factors. The objective functional benefit was not provided. The request as submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating a necessity for 2 benzodiazepines. Given the above, the request for 1 prescription for Valium 5mg #30 is not medically necessary.

1 prescription of Gabapentin 600mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend anti-epilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30 % - 50% and objective functional improvement. The clinical documentation submitted for review failed to provide documentation of an objective decrease in pain of at least 30% to 50% with use of the medication and there was a lack of documentation of objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for 1 prescription of gabapentin 600 mg #90 is not medically necessary.