

Case Number:	CM15-0047543		
Date Assigned:	03/19/2015	Date of Injury:	08/13/2013
Decision Date:	04/24/2015	UR Denial Date:	03/04/2015
Priority:	Standard	Application Received:	03/12/2015

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: Arizona, 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 38-year-old female who sustained an industrial injury on 8/13/03. The injured worker reported symptoms in the neck and bilateral upper extremities. The injured worker was diagnosed as having impingement syndrome of shoulder on the right with bicipital tendonitis status post decompression and labral repair, cubital tunnel on the right status post release, stenosing tenosynovitis, discogenic cervical condition, and carpometacarpal joint inflammation right thumb. Treatments to date have included oral pain medications, topical patches, injections, transcutaneous electrical nerve stimulation unit, braces, hot and cold wraps, and activity modification. Currently, the injured worker complains of pain in the neck and bilateral upper extremities. The plan of care was for medication prescriptions and a follow up appointment at a later date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin patches #20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-112.

Decision rationale: Terocin patch contains .025% Capsacin, 25% Menthyl Salicylate, 4% Menthol and 4% Lidocaine. According to the MTUS guidelines, topical analgesics are recommended as an option as indicated below. They 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. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Lidocaine is 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). In this case, the claimant was on a tricyclic and topical Lidocaine cream separately. Pain response to all the redundant modalities is difficult to determine and is not proven to provide added benefit. In addition, other topical formulations of Lidocaine are not approved. Any compounded drug that is not recommended is not recommended and therefore Terocin patches are not medically necessary.

LidoPro lotion 4oz: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-112.

Decision rationale: According to the MTUS guidelines, topical analgesics are recommended as an option as indicated below. They 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. Lidocaine is 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). Lidoderm has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. In this case, the claimant did not have the above diagnoses. The claimant had been on Trazadone, a tricyclic, without indication of its failure. The claimant had been simultaneously given Terocin topical, which contains Lidocaine. There is no indication for redundant use of topical analgesics. The continued use of LidoPro cream is not medically necessary.

Trazodone 50mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-depressants Page(s): 14-18.

Decision rationale: Trazadone is a tricyclic antidepressant. According to the MTUS guidelines, this class of medications is to be used for depression, radiculopathy, back pain, and fibromyalgia. Tricyclic antidepressants have been shown in both a meta-analysis and a systematic review to be effective, and are considered a first-line treatment for neuropathic pain. It has not been proven beneficial for lumbar root pain. In this case, the Trazadone was combined with muscle relaxants, opioids, NSAIDs, topical analgesics and other antidepressants. There is no indication for multiple forms of analgesics without documented pain response, length of use or reason for sequential additional of each and all medications. The continued use of Trazadone is neither substantiated nor supported by evidence and is not medically necessary.