

Case Number:	CM15-0057550		
Date Assigned:	04/17/2015	Date of Injury:	03/24/2014
Decision Date:	07/21/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	03/26/2015

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: New York

Certification(s)/Specialty: Emergency Medicine

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 female who sustained progressive, cumulative industrial injuries on 3/24/14 resulting from repetitive work. She reported right hand and right elbow swelling. She was given anti-inflammatory medications, topical patches, hand and elbow braces. She currently complains of intermittent right shoulder pain (7/10) radiating to the right elbow (9/10), right hand pain (9/10). Activities of daily living are limited. Medications are LidoPro ointment, cyclobenzaprine, pantoprazole, Terocin patches. Diagnoses include right shoulder impingement, rotator cuff inflammation and mild bicipital tendinitis as well as anterior cruciate joint inflammation; medial greater than lateral epicondylitis on the right; wrist joint inflammation on the right. Treatments to date include physical therapy; elbow sleeve; cold and heat pad; left elbow strap which is not effective for pain; medications. Diagnostics include x-rays of entire right upper extremity (no date). In the progress note dated 2/3/15 the treating provider's plan of care requested soft wrist brace for the right hand; elbow pad, hot and cold compression garment; transcutaneous electrical nerve stimulator unit; Flexeril for muscle spasms; Nalfon for inflammation; Protonix to buffer the stomach; LidoPro ointment and Terocin patches for topical relief.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF or muscle stimulator qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS), Transcutaneous electrotherapy Page(s): 116-119.

Decision rationale: According to the reference Ca MTUS guidelines, interferential current stimulation is "not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." There are no standardized protocols for the use of interferential stimulation. If certain criteria are met, a one month trial may be appropriate to permit the physician and physical medicine provider to determine effects and benefits. Criteria include pain which is ineffectively controlled by medications, history of substance abuse, pain from postoperative conditions that limit the ability to perform exercise programs, or lack of response to conservative measures. The documentation supports the IW is participating in occupation and physical therapy sessions which supports her ability to perform exercise programs. Additionally, the IW is using medications, which have been requested for refill suggesting tolerance and benefit. Additionally, the Injured Worker has return to work supporting improvement with conservative measures without the supporting documentation, the IF unit is not medically necessary.

Conductive garment qty: 1.00: 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).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS), transcutaneous electrotherapy Page(s): 116-119.

Decision rationale: The request for a conductive garment implies its use with an interferential current stimulation program. As discussed above, and IF system is determined to be not medically necessary according to the reference Ca MTUS guidelines, interferential current stimulation, is "not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." There are no standardized protocols for the use of interferential stimulation. If certain criteria are met, a one month trial may be appropriate to permit the physician and physical medicine provider to determine effects and benefits. Criteria include pain which is ineffectively controlled by medications, history of substance abuse, pain from postoperative conditions that limit the ability to perform exercise programs, or lack of response to conservative measures. The documentation supports the Injured Worker is participating in occupation and physical therapy sessions which supports her ability to perform exercise programs. Additionally, the Injured Worker is using medications which have been requested for refill suggesting tolerance and benefit. Additionally, the IW has return to work supporting improvement with

conservative measures. With respect to a conductive garment, should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. Without the supporting documentation, the conductive garment is not medically necessary.

Lidopro ointment 121gm 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 Lidoderm, Topical Analgesic Page(s): 56-57; 111-112.

Decision rationale: Lidopro is a topical ointment consisting of the ingredients capsaicin, lidocaine, menthol and methyl salicylate ointment. According to CA MTUS chronic pain guidelines, 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). Topical lidocaine, in the formulation of a dermal patch Lidoderm patch is the only commercially approved topical formulations of lidocaine for indicated neuropathic pain. For non-neuropathic pain, lidocaine is not recommended. The requested formulation is an ointment and not the approved patch. In addition, the request does not include the intended location or frequency of application. Without this information, the request is not medically necessary.

Cyclobenzaprine 7.5mg qty: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41, 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine Page(s): 41-42.

Decision rationale: According to CA MTUS, cyclobenzaprine is recommended as an option for short course of therapy. Effect is noted to be modest and is greatest in the first 4 days of treatment. The Injured Worker has been receiving this prescription for a minimum of 6 months according to submitted records. This greatly exceeds the recommended timeframe of treatment. In addition, the request does not include dosing frequency or duration. The Injured Worker's response to this medication is not discussed in the documentation. The request is not medically necessary.

Pantoprazole 20mg qty: 60.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: According to CA MTUS, gastrointestinal protectant agents are recommended for patients that are at increased risk for gastrointestinal events. These risks include age >65, history or gastrointestinal bleeding or peptic ulcers, concomitant use of NSAIDs and corticosteroids or aspirin, or high dose NSAID use. The chart does not document any of these risk factors. Past medical history does not include any gastrointestinal disorders, there is no history of poor tolerance to NSAIDs documented and there are not abdominal examinations noted in the chart. Pantoprazole is not medically necessary based on the MTUS.

Terocin patches qty: 20.00: 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 Medications for chronic pain Page(s): 111-113, 60. Decision based on Non-MTUS Citation "<http://www.drugs.com/pro/terocin.html>".

Decision rationale: The treating physician has not discussed the ingredients of Terocin and the specific indications for this injured worker. Per the manufacturer, Terocin is Methyl Salicylate 25%, Menthol 10%, Capsaicin 0.025%, Lidocaine 2.5%, Aloe, Borage Oil, Boswellia Serrata, and other inactive ingredients. Per page 60 of the MTUS, medications should be trialed one at a time. Regardless of any specific medication contraindications for this patient, the MTUS recommends against starting 3-7 medications simultaneously. Per the MTUS, any compounded product that contains at least one drug that is not recommended is not recommended. Boswellia serrata resin and topical lidocaine other than Lidoderm are "not recommended" per the MTUS. Capsaicin alone in the standard formulation readily available OTC may be indicated for some patients. The indication in this case is unknown, as the patient has not failed adequate trials of other treatments. Capsaicin is also available OTC, and the reason for compounding the formula you have prescribed is not clear. Terocin is not medically necessary based on lack of specific medical indications, the MTUS, lack of medical evidence, FDA directives, and inappropriate prescribing.

Elbow pad qty: 1.00: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) wrist: padding, splinting.

Decision rationale: Ca MTUS is silent on this topic. The referenced ODG guidelines discuss elbow padding with respect to splinting. It is unclear from the request, what an "elbow pad" is referencing. It does not include condition intended to treat, laterality of pad or intended timeframe of use. Within the ODG guidelines, padding is recommended for cubital tunnel

syndrome. This includes, "a splint or foam elbow pad worn at night (to limit movement and reduce irritation), and/or an elbow pad (to protect against chronic irritation from hard surfaces)." The IW does not have a diagnosis of cubital tunnel syndrome. Without the supporting documentation, the request for an elbow pad is not medically necessary.

Right hand soft brace qty: 1.00: 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), Durable medical equipment (DME).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265-266. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) forearm, wrist: splints.

Decision rationale: The ACOEM cited above supports the use of wrist splinting for the treatment of carpal tunnel syndrome. These splints are recommended for a treatment period of time (four weeks) with a splint and medications before injection is considered, except in the case of severe carpal tunnel syndrome (thenar muscle atrophy and constant paresthesias in the median innervated digits). The ODG guidelines recommend the use of splints is recommended for treating displaced fractures as well as tendon repair. The Injured Worker does not have a diagnosis of carpal tunnel syndrome, nor has she had recent wrist surgery. In addition, the request does not include laterality and intended timeframe of use. Without this information, the request is not medically necessary.