

<b>Case Number:</b>	CM14-0211462		
<b>Date Assigned:</b>	02/03/2015	<b>Date of Injury:</b>	04/29/1997
<b>Decision Date:</b>	03/06/2015	<b>UR Denial Date:</b>	11/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2014

### 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. 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 patient is a 63-year old female with a work injury dated 4/29/97. The diagnoses include impingement syndrome left shoulder with post decompression; impingement syndrome right shoulder-status post decompression; partial right rotator cuff tear (not able to be repaired at times of surgery); neck sprain with facet inflammation. Under consideration are requests for Terocin Patches; LidoPro Lotion; Protonix; Norflex; Lidoderm Patch. There is a progress note dated 10/23/14 that states that the patient rates her shoulder pain 6/10. She reports increased bilateral shoulder stiffness and spasms. She denies numbness/tingling lately. She has trouble gripping but can do basic chores. She walks with pain and has depression due to chronic pain. On exam she had left upper extremity abduct to 100 degrees and right upper extremity laterally abducts to 85 degrees.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Prescription of Terocin Patches #30 with 1 refill: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Menthol & Topical Analgesics & Lidoderm Page(s): 105, 111-113 and 56.

**Decision rationale:** One Prescription of Terocin Patches #30 with 1 refill is not medically necessary per MTUS Chronic Pain Medical Treatment Guidelines. A Terocin patch contains: Menthol 4%; Lidocaine 4%. Per MTUS guidelines, topical lidocaine in the form of a creams, lotions or gel is not indicated for neuropathic pain. The guidelines state that lidocaine in a patch form 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). and is only FDA approved for post-herpetic neuralgia. The MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Furthermore, the MTUS guidelines state that compounded products that contains at least one drug (or drug class) that is not recommended is not recommended. Although Menthol is not specifically addressed in the MTUS menthol is present in Ben Gay which is recommended by the MTUS. Due to the fact that documentation submitted does not show evidence of intolerance to oral medications, failure of first-line therapy and no indication of postherpetic neuralgia in this patient Terocin patch is not medically necessary.

**1 Prescription of Lido Pro Lotion #4oz with 1 refill: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics & Menthol & Methyl Salicylate Page(s): 105 and 111-113 (methyl salicylate).

**Decision rationale:** One Prescription of Lido Pro Lotion #4oz with 1 refill is not medically necessary per MTUS guidelines. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Lidopro is a combination of Capsaicin 0.0325%; Lidocaine 4.5%; Menthol 10%; Methyl Salicylate 27.5%. Per MTUS guidelines, 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. Furthermore, Topical Lidocaine 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). There is no evidence patient has tried the above mentioned first line therapy medications. In addition, there is little to no research to support the use of many of these agents. When one ingredient in a topical formulation is not recommended the MTUS does not support the entire product. For these reasons, LidoPro cream is not medically necessary .

**1 Prescription of Protonix 20mg #60 with 1 refill: Upheld**

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

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

**Decision rationale:** One Prescription of Protonix 20mg #60 with 1 refill is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines and the ODG. The MTUS guidelines state that the patient is at risk for gastrointestinal events if they meet the following criteria (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The guidelines also state that a proton pump inhibitor can be considered if the patient has NSAID induced dyspepsia. The documentation does not indicate that the patient meets the criteria for a proton pump inhibitor. Furthermore, the ODG does not recommend Protonix unless there is a need and the patient has had a failure of first line proton pump inhibitor trials. For all of these reasons the request for 1 Prescription of Protonix 20mg #60 with 1 refill is not medically necessary.

**1 Prescription of Norflex 100mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Orphenadrine & Muscle Relaxants Page(s): 65 & 63.

**Decision rationale:** One Prescription of Norflex 100mg #60 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that Norflex can be used as a second line option for short term treatment of acute exacerbations of low back pain. The guidelines state that in most cases they show no benefit beyond NSAIDs in pain and overall improvement. The documentation indicates that the patient has been on Norflex since 4/18/14 without functional improvement. The continued use of Norflex is not medically necessary.

**1 Prescription of Lidoderm Patch 5% #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56.

**Decision rationale:** One prescription of Lidoderm Patch 5% #60 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that topical lidocaine 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). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. The documentation does not indicate failure of first line

therapy for peripheral pain. The documentation does not indicate a diagnosis of post herpetic neuralgia. For these reasons the request for Lidoderm Patch 5% is not medically necessary.