

<b>Case Number:</b>	CM15-0173809		
<b>Date Assigned:</b>	09/15/2015	<b>Date of Injury:</b>	09/24/2009
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	08/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/03/2015

### 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: Physical Medicine & Rehabilitation, Pain Management

### 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 69 year old male, who sustained an industrial injury on September 24, 2009. A review of the medical records indicates that the injured worker is undergoing treatment for pain in joint of lower leg, lumbago, sciatica, and thoracic or lumbosacral neuritis or radiculitis. On July 27, 2015, the injured worker reported lower back, left knee, and right knee pain, that radiates to the upper back, middle back, lower back, left buttock, right buttock, bilateral hips, bilateral thighs, and bilateral knees, with poor quality of sleep. The Treating Physician's report dated July 27, 2015, noted the injured worker rated his pain as 7 out of 10 with zero being no pain and 10 having the worst pain possible. The injured worker was noted to be able to walk for 1-2 blocks, sit for one hour, and stand for 15 minutes, with difficulty working, performing household chores, doing yard work, participating in recreational activities, and exercising, constantly needing to lie down due to the pain. The injured worker was noted to not be taking any medications at the time. Physical examination was noted to show the injured worker with an analgic slowed gait, with restricted range of motion (ROM) of the lumbar spine. The lumbar spine examination was noted to show loss of normal lordosis, spasm and tenderness noted on palpation of the paravertebral muscles, tenderness over the sacroiliac spine, positive lumbar facet loading bilaterally, and bilateral positive straight leg raise. The knees examination was noted to show restricted range of motion (ROM) and tenderness to palpation over the lateral joint line and medial joint line. The Physician noted prescriptions for Lidopro ointment, Naproxen, Pantoprazole Sodium, and Terocin patches. The injured worker's CURES report and opioid agreement were noted to be reviewed. Prior treatments have included 18 sessions of

acupuncture, 12 sessions of physical therapy, a trial of a TENS unit, cortisone injections to both knees, and a trial of Gabapentin. A urine drug screen (UDS) dated July 27, 2015, noted Gabapentin to be detected but no part of the prescription list of "no reported prescriptions". The request for authorization dated August 14, 2015, retrospectively requested a tube of Lidopro 4% ointment, Naproxen Sodium 550mg #60, Terocin 4-4% patches #30, and Pantoprazole Sodium DR 20mg #60, all for the date of service of July 27, 2015. The Utilization Review (UR) dated August 20, 2015, non-certified the retrospective requests for a tube of Lidopro 4% ointment, Naproxen Sodium 550mg #60, Terocin 4-4% patches #30, and Pantoprazole Sodium DR 20mg #60, all for the date of service of July 27, 2015.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Retro tube of Lidopro 4% ointment, DOS: 7/27/15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Regarding request for topical lidocaine, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the first line therapy such as tricyclic antidepressants, SNRIs, or antiepileptic drugs. Guidelines further stipulate that no commercially approved topical formulations of lidocaine cream, lotion, or gel are indicated for neuropathic pain. Thus, these guidelines do not support the use of topical lidocaine preparations which are not in patch form. As such, the currently requested topical formulation which contains lidocaine is not medically necessary.

**Retro Naproxen Sodium 550mg #60, DOS: 7/27/15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**Decision rationale:** Regarding the request for Naproxen, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Naproxen is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. Given this, the current request is not medically necessary.

**Retro Terocin 4-4% patches #30, DOS: 7/27/15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Regarding the request for Terocin, Terocin is a combination of methyl salicylate, menthol, lidocaine and capsaicin. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Regarding the use of topical non-steroidal anti-inflammatory, guidelines state that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the 1st 2 weeks of treatment osteoarthritis, but either not afterwards, or with the diminishing effect over another two-week period. Within the submitted documentation, there is no documentation of intolerance to oral NSAIDs. Regarding use of capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to or are intolerant to other treatments. Regarding the use of topical lidocaine, guidelines the state that it is recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Within the documentation available for review, there is no documentation of localized peripheral pain with evidence of failure of first-line therapy as recommended by guidelines prior to the initiation of topical lidocaine. Furthermore only topical lidocaine in patch form as Lidoderm is recommended per CPMTG, and thus this component is not recommended. Therefore, the currently requested Terocin is not medically necessary.

**Retro Pantoprazole Sodium DR 20mg #60, DOS: 7/27/15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, PPI.

**Decision rationale:** Regarding the request for pantoprazole (Protonix), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Additionally, ODG recommends Nexium, Protonix, Dexilant, and AcipHex for use as 2nd line agents, after failure of omeprazole or lansoprazole. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. Furthermore, there is no indication that the patient has failed first-line agents prior to initiating treatment with pantoprazole (a 2nd line proton pump inhibitor). In the absence of clarity regarding those issues, the currently requested pantoprazole is not medically necessary.