

<b>Case Number:</b>	CM13-0006816		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	02/05/2012
<b>Decision Date:</b>	05/16/2014	<b>UR Denial Date:</b>	07/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/05/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 27 year-old male warehouse worker sustained an injury on 2/5/12 while employed by [REDACTED]. Requests under consideration include Compound medication Somnicin, Genicin, Topical compound analgesics Ketoprofen/ Lidocaine, and Gabapentin/ Ketoprofen/ Cyclobenzaprine for the lumbar spine. Diagnosis included lumbosacral sprain/ strain. Report of 1/21/13 from [REDACTED] noted patient with lumbosacral pain. Exam noted tender lumbar paravertebrals with treatment plan for medications and physical therapy. The retrospective requests received by utilization reviewer on 6/5/13 were non-certified on 7/23/13 citing guidelines criteria and lack of medical necessity. Report from [REDACTED], pain management on 4/1/13 noted review of pertinent diagnostic studies and reports: MRI of lumbar spine dated 1/8/13 with 4 mm disc bulge at L4-5 and 1-2 mm disc bulge at L5-S1 without evidence of significant neural foraminal or canal stenosis; EMG/NCV of lower extremities on 2/22/13 had normal impression; report of 2/17/13 from [REDACTED] noted treatment plan for refill of topical compounds, continue pain medications, continue physical therapy/ hot and cold thermo; and consider LESI. [REDACTED] noted patient to be an excellent candidate for Lumbar epidural steroid injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE REQUEST FOR COMPOUND MEDICATION SOMNICIN FOR THE LUMBAR SPINE: 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).

**Decision rationale:** Compound medication Somnicin has Melatonin, 5-HTP, L-Tryptophan, VitB6, and Magnesium. Regarding sleep aids, the Official Disability Guidelines (ODG) states that preliminary evidence demonstrates the value of Melatonin and Amitriptyline in treating sleep disorder post-TBI; however, there are documented diagnoses of such. Submitted reports have not demonstrated any evidence-based studies or medical report to indicate necessity of the above treatment. There is no report of sleep disorder. In order to provide a specific treatment method, the requesting physician must provide clear objective documentation for medical indication; functional improvement goals' expected or derived specifically relating to the patient's condition as a result of the treatment(s) provided. Documentation of functional improvement may be a clinically significant improvement in activities of daily living, a reduction in work restrictions and a reduction in the dependency on continued medical treatment. Absent the above described documentation, there is no indication that the specific treatment method is effective or medically necessary for this patient. The retrospective request for compound medication Somnicin for the lumbar spine is not medically necessary and appropriate.

**RETROSPECTIVE REQUEST FOR GENICIN FOR THE LUMBAR SPINE: 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 Glucosamine (and Chondroitin Sulfate) Page(s): 50-51.

**Decision rationale:** Genicin (Glucosamine) is listed as a nutritional supplement that are naturally occurring substance formed of sugar chains believed to help maintain joint cartilage and fluid in patients with osteoarthritis for better movement and flexibility. MTUS Chronic Pain Medical Treatment Guidelines do support its use as an option given its low risk in patients with moderate arthritis pain for knee osteoarthritis (OA); however, there is no diagnostic or clinical findings mentioned for OA nor was there any impression of OA submitted reports. The retrospective request for Genicin for the lumbar spine is not medically necessary and appropriate.

**RETROSPECTIVE REQUEST FOR KETOPROFEN/LIDOCAINE FOR THE LUMBAR SPINE: 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 Topical Analgesics Page(s): 111-113.

**Decision rationale:** According to the MTUS Chronic Pain ,Medical Treatment Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic over oral NSAIDs or other pain relievers for a patient without contraindication in taking oral medications. Based on the medical records provided for review the patient is already taking multiple other oral pain medications and there is no demonstrated functional improvement from ongoing refills of medication. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic. Of particular note, Ketoprofen cream is an agent not currently FDA approved for a topical application due to an extremely high incidence of photocontact dermatitis. The retrospective request for Ketoprofen/Lidocaine for the lumbar spine is not medically necessary and appropriate.

**RETROSPECTIVE REQUEST FOR GABAPENTIN-KETOPROFEN-CYCLOBENZAPRINE FOR THE LUMBAR SPINE: 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 Topical Analgesics Page(s): 111-113.

**Decision rationale:** According to the MTUS Chronic Pain Medical Treatment Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic over oral NSAIDs or other pain relievers for a patient without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic. The retrospective request for Gabapentin/Ketoprofen/Cyclobenzaprine for the lumbar spine is not medically necessary and appropriate.