

<b>Case Number:</b>	CM13-0011197		
<b>Date Assigned:</b>	04/23/2014	<b>Date of Injury:</b>	02/08/2010
<b>Decision Date:</b>	06/02/2014	<b>UR Denial Date:</b>	07/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/14/2013

### 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 & Rehabilitation, has a subspecialty in Pain Management 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:

This is a female patient with a date of injury of February 8, 2010. A utilization review determination dated July 25, 2013 recommends noncertification for 2 topical compound medications, Somnicin, cyclobenzaprine, omeprazole, and Fioricet. A progress report dated July 16, 2013 includes subjective complaints of cervical spine pain with radiation of pain, numbness, and weakness. Medications only helped temporarily. The patient also complains of right shoulder pain with stiffness and weakness, and right wrist pain which is intermittent. Objective examination findings identify tenderness and spasm upon palpation of the cervical spine with limited range of motion. The right shoulder also has tenderness with limited range of motion. The right wrist also has tenderness with limited range of motion. Diagnoses include cephalgia, stress, right shoulder pending surgery, lumbar spine discopathy, cervical spine discopathy, and a history of severe asthma. The current treatment plan recommends Fioricet, Prilosec, Somnicin, Flexeril, ketoprofen cream, and capsaicin cream. A progress report dated March 11, 2014 has boxes checked indicating right shoulder pain, cervical pain, and wrist pain. Objective findings have items circled including cervical spine, shoulder, and wrist tenderness to palpation and reduced range of motion. The treatment plan recommends Fioricet, Norco, Flexeril, Somnicin, and two compound creams.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CAP/MENT/CAMP/HYALURONIC 0.05%/2%/1%/0.2% CREAM TO AFFECTED AREA 2-3 TIMES DAILY120ML 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 Topical Analgesics Page(s): 111-113.

**Decision rationale:** 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 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 Hyaluronic acid, guidelines do not support the use of hyaluronic acid in topical formulation. Within the documentation available for review, there is no indication that the patient has been intolerant to or did not respond to other treatments prior to the initiation of capsaicin therapy. Additionally, there is no support for topical hyaluronic acid. In the absence of clarity regarding those issues, the currently requested topical compound (CAP/MENT/CAMP/HYALURONIC) is not medically necessary.

**KETOPROFEN/LIDOCAINE 10%/5% CREAM TO AFFECTED AREA 2-3 TIMES DAILY 120 ML 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 Topical Analgesics Page(s): 111-112.

**Decision rationale:** 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 nonsteroidal 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. Regarding the use of topical local anesthetics (lidocaine), guidelines state that they are recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Guidelines do not support topical lidocaine in anything other than a patch formulation. Within the documentation available for review, there is no indication that the patient is unable to tolerate oral NSAIDs. Oral NSAIDs have significantly more guideline support compared with topical NSAIDs. Additionally, there is no indication that the topical NSAID is going to be used for short duration. Additionally, 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, and a lack of guideline support for non-patch lidocaine. In the absence of clarity regarding those issues, the currently requested ketoprofen/lidocaine 10%/5% cream is not medically necessary.

**SOMNICIN CAPSULE AT BEDTIME QTY:30.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Medical Food.

**Decision rationale:** A search of the Internet indicates that Somnicin is a medical food. California MTUS and ACOEM guidelines do not contain criteria for the use of medical foods. ODG states that medical foods are recommended for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements. Within the documentation available for review, the requesting physician has not indicated that this patient has any specific nutritional deficits. Additionally, there are no diagnoses, conditions, or medical disorders for which distinctive nutritional requirements are present. In the absence of such documentation, the currently requested Somnicin is not medically necessary.

**CYCLOBENZAPRINE 10MG 3 TIMES DAILY QTY:90.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS Page(s): 64-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Flexeril is not medically necessary.

**OMEPRAZOLE 20MG 1-2 TIMES DAILY QTY:60.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 68-69.

**Decision rationale:** 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. 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. In light of the above issues, the currently requested omeprazole is not medically necessary.

**FIORICET 325/50/40MG EVERY 4-6 HOURS AS NEEDED QTY:120.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-Containing Analgesic Agents Page(s): 23.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-Containing Analgesic Agents Page(s): 23.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state that barbiturate-containing analgesic agents are not recommended for chronic pain. They go on to state that the potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. As such, the currently requested Fioricet is not medically necessary.