

<b>Case Number:</b>	CM13-0015463		
<b>Date Assigned:</b>	10/10/2013	<b>Date of Injury:</b>	09/08/2012
<b>Decision Date:</b>	01/28/2014	<b>UR Denial Date:</b>	08/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/23/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice 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 physician 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 44-year-old female who reported an injury on 09/08/2012. The patient developed chronic low back pain and left knee pain that was treated with medications. The patient underwent an MRI in 04/2013 that revealed a disc protrusion at the L3-4 and L4-5. The patient also underwent an MRI of the left knee which revealed there is an altered contour of the posterior horn of the medial meniscus, evidence of an anterior cruciate ligament sprain, thickening of the medial collateral ligament with small joint effusion. The patient underwent and electro diagnostic study that did not provide any abnormal findings. Physical findings included an antalgic gait, lumbosacral tenderness with limitation of range of motion secondary to pain, patellofemoral tenderness of the left knee, medial facet tenderness of the left knee, and a positive apprehension sign in the left knee. The patient's diagnosis included lumbar radiculopathy. The patient's treatment plan included continuation of medications, topical analgesics, an MRI of the left knee, and low back.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Magnetic resonance imaging (MRI) of lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, MRI.

**Decision rationale:** The Physician Reviewer's decision rationale: The requested MRI of the lumbar spine is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient recently underwent an MRI of the lumbar spine. American College of Occupational and Environmental Medicine recommend MRIs of the lumbar spine in the presence of neurological deficits. The clinical documentation submitted for review did not provide any evidence of neurological deficits upon physical examination. Additionally, Official Disability Guidelines do not recommend repeat imaging studies unless there is progressive neurological deficits or a significant change in pathology. The clinical documentation submitted for review does not provide any evidence of significant change in pathology or progressive neurological deficits. As such, the requested magnetic resonance imaging of the lumbar spine would not be considered medically necessary or appropriate.

**Magnetic resonance imaging (MRI) of left knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343.

**Decision rationale:** The Physician Reviewer's decision rationale: The requested MRI of the left knee is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has continued pain complaints and range of motion deficits related to the left knee. However, the patient recently underwent an MRI. American College of Occupational and Environmental Medicine recommend MRIs in the presence of red flags or the suspicion of internal derangement. Additionally, Official Disability Guidelines do not recommend repeat imaging unless there is a progressive change in symptoms or pathology. The clinical documentation submitted for review does not provide any evidence that the patient has had a significant change in presentation since the prior MRI. As such, the requested MRI of the left knee is not medically necessary or appropriate.

**Terocin 240ml:**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics and Medications for Chronic Pain Page(s): 111-113,60.

**Decision rationale:** The Physician Reviewer's decision rationale: The requested Terocin 240 ml is not medically necessary or appropriate. The patient does have continued pain complaints of the lumbar spine and left knee. The requested Terocin cream contains methyl salicylate,

capsaicin, menthol, and lidocaine. The California Medical Treatment Utilization Schedule does recommend the use of methyl salicylate and menthol as a topical agent. However, the use of capsaicin is only recommended for patients who are intolerant or unresponsive to other treatments. The clinical documentation submitted for review does not provide any evidence that the patient has been unresponsive or intolerant to other treatments including oral analgesics. Additionally, the California Medical Treatment Utilization Schedule states that "no other commercially approved topical formulation of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain." Additionally, the California Medical Treatment Utilization Schedule recommends the introduction of pain medications for the management of chronic pain be introduced 1 at a time. Therefore, a formulation of medications with multiple medications would not be indicated. Also, any compounded agent with an element that is not recommended is not supported by guideline recommendations. As such, the requested Terocin 240 mL is not medically necessary or appropriate.

**Capsaicin 0.025%/Methyl Salicylate 25%/Menthol 10%/Lidocaine 2.5%, apply 3-4 x day:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics and Medications for Chronis pain Page(s): 111-113,60.

**Decision rationale:** The Physician Reviewer's decision rationale: The requested Capsaicin 0.025%/Methyl Salicylate 25%/Menthol 10%/Lidocaine 2.5%, is not medically necessary or appropriate. The patient does have continued pain complaints of the lumbar spine and left knee. The requested Terocin cream contains methyl salicylate, capsaicin, menthol, and lidocaine. The California Medical Treatment Utilization Schedule does recommend the use of methyl salicylate and menthol as a topical agent. However, the use of capsaicin is only recommended for patients who are intolerant or unresponsive to other treatments. The clinical documentation submitted for review does not provide any evidence that the patient has been unresponsive or intolerant to other treatments including oral analgesics. Additionally, the California Medical Treatment Utilization Schedule states that "no other commercially approved topical formulation of lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain." Additionally, the California Medical Treatment Utilization Schedule recommends the introduction of pain medications for the management of chronic pain be introduced 1 at a time. Therefore, a formulation of medications with multiple medications would not be indicated. Also, any compounded agent with an element that is not recommended is not supported by guideline recommendations.

**Furbi (NAP) cream LA-180gms: Flurbiprofen 20%/Lidocaine 5%/Amitriptyline 4%, apply 2-3 x day:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics and Medications for Chronic Pain Page(s): 111-113,60. Decision based on Non-MTUS Citation Skolnick P (1999) Antidepressants for the new millennium. Eur J Pharmacol 375:31-40.

**Decision rationale:** The Physician Reviewer's decision rationale: The requested flurbiprofen cream LA-180 gms: Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 4%, apply 2-3 x day is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has continued pain complaints of the low back and left knee. California Medical Treatment Utilization Schedule does not recommend the use of topical agents as they are largely experimental and not scientifically supported. California Medical Treatment Utilization Schedule does not support the use of flurbiprofen as a nonsteroidal anti-inflammatory drug unless there is documentation that the patient has failed to respond to oral analgesics. The clinical documentation does not include any evidence that the patient is intolerant or that oral formulations of nonsteroidal anti-inflammatory drugs are contraindicated for this patient. The compounded cream also includes lidocaine. California Medical Treatment Utilization Schedule does not recommend the use of lidocaine in a cream formulation as it is not FDA approved. California Medical Treatment Utilization Schedule and Official Disability Guidelines do not specifically address topical applications of antidepressants. However, peer-reviewed literature states that while local peripheral administration of antidepressants have been demonstrated to produce analgesia, there is a lack of scientific evidence to support the benefit of this type of medication. Additionally, California Medical Treatment Utilization Schedule recommends the use medications be introduced singularly when managing a patient's chronic pain. Therefore, a compounded agent would not be supported by guideline recommendations. As such, the requested Furbi (NAP) cream LA-180gms: Flurbiprofen 20%/Lidocaine 5%/Amitriptyline 4%, apply 2-3 x day is not medically necessary or appropriate.

**Gabocyclotram 180gms/Gabapentin 10%/Cyclobenzaprine 6%/Tramadol 10%, apply 2-3 x day:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics and Medications for Chronic Pain. Decision based on Non-MTUS Citation Effectiveness of topical administration of opioids in palliative care: a systematic review, B LeBon, G Zeppetella, IJ Higginson - Journal of pain and symptoms,2009 - Elsevier

**Decision rationale:** The Physician Reviewer's decision rationale: The requested Gabocyclotram is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has continued low back and left knee complaints. California Medical Treatment Utilization Schedule does not recommend any compounded formulation that contains at least 1 drug or drug class that is not supported by guideline recommendations. The use of gabapentin is not supported by guideline recommendations. California Medical Treatment Utilization Schedule also does not recommend the use of muscle relaxants as a topical agent due to lack of scientific evidence to support efficacy of this type of medication in a topical agent.

California Medical Treatment Utilization Schedule and Official Disability Guidelines do not address opioids as topical agents. However, peer-reviewed literature supports that there is a lack of scientific evidence to support the use of opioids in a topical formulation. Additionally, California Medical Treatment Utilization Schedule recommends the use of medications in a patient's management of chronic pain be introduced singularly. Therefore, a compounded medication would not be supported. As such, the requested Gabocyclotram 180 gms/Gabapentin 10%/Cyclobenzaprine 6%/Tramadol 10%, apply 2-3 x day is not medically necessary or appropriate.

**Genicin #90: Glucosamine sodium 500mg, take as directed: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain and Glucosamine Page(s): 60,50.

**Decision rationale:** The Physician Reviewer's decision rationale: The requested Genicin #90 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has chronic low back pain and left knee pain. California Medical Treatment Utilization Schedule does recommend the use of glucosamine sodium in the management of degenerative disease. However, California Medical Treatment Utilization Schedule also states that continued use of a medication in the management of the patient's chronic pain be supported by functional benefit and symptom response. The clinical documentation submitted for review does not provide any evidence that the patient has received any functional benefit or pain relief as a result of this medication usage. As such, the requested Genicin #90: Glucosamine sodium 500mg, take as directed is not medically necessary or appropriate.

**Somnicin #30: Melatonin 2mg/5HTP 50mg/L tryptophan 100mg/Pyridoxine 10mg/Magnesium 50mg: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Insomnia Treatment.

**Decision rationale:** The Physician Reviewer's decision rationale: The requested Somnicin #30 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has significant low back pain complaints. Official Disability Guidelines recommend medication management of insomnia after the patient has failed to respond to nonpharmacological methods. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to nonpharmacological treatments. Additionally, California Medical Treatment Utilization Schedule recommends the continued use

of medications in the management of patient's chronic pain be supported by functional benefit and symptom response. The clinical documentation submitted for review does not provide any evidence of functional benefit or significant symptom response as it relates to this medication. Therefore, continued use would not be indicated. As such, the requested Somnicin #30: Melatonin 2mg/5HTP 50mg/L tryptophan 100mg/Pyridoxine 10mg/Magnesium 50mg is not medically necessary or appropriate.

**One time Proove Biosciences narcotic Risk lab test: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Urine Drug Screens.

**Decision rationale:** The Physician Reviewer's decision rationale: The requested Proove Biosciences narcotic Risk lab test is not medically necessary or appropriate. Clinical documentation submitted for review does indicate that the patient has chronic low back pain and left knee pain. This pain has been managed with medications. California Medical Treatment Utilization Schedule recommends the use of drug testing when there is suspicion of aberrant behavior to the patient's prescribed medication schedule or use of illicit street drugs. The clinical documentation submitted for review does not provide any evidence that the patient is suspected of aberrant behavior or of using illicit street drugs. Additionally, there is no indication within the documentation that any drug testing determined to be necessary by the treating physician cannot be handled at a lower level point-of-care test. Official Disability Guidelines recommend the use of point-of-care test prior to confirmatory or out of office lab testing. As such, the requested 1 time Proove Biosciences narcotic Risk lab test is not medically necessary or appropriate.