

Case Number:	CM13-0033894		
Date Assigned:	12/06/2013	Date of Injury:	06/18/2013
Decision Date:	01/31/2014	UR Denial Date:	10/01/2013
Priority:	Standard	Application Received:	10/11/2013

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 Texas. 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 52-year-old female who reported an injury on 06/18/2013 as a result of pushing a trash cart that got hung on the pavement that caused her and the cart to fall over. The patient was initially diagnosed with a cervical sprain/strain, thoracic sprain/strain, lumbar sprain/strain, and left shoulder internal derangement. The patient was treated conservatively with medications and physical therapy. The patient underwent left shoulder rotator cuff repair and subacromial decompression on 11/14/2013. The patient's medication schedule included Cyclobenzaprine, Terocin patches, other topical agents, and Norco 10/325 mg. The patient's most recent clinical evaluation findings included restricted cervical range of motion and cervical spine spasms, decreased lumbar range of motion in all planes secondary to pain and spine spasms, and a positive straight leg raising test bilaterally. The patient's diagnoses included neck sprain/strain, cervical disc protrusion, brachial neuritis or radiculitis, thoracic and lumbar sprain/strain, lumbar disc protrusion, lumbar radiculopathy, and left shoulder internal derangement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin 0.025%-25% #240 per 08/27/13 RX: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The requested Terocin topical medication is not medically necessary or appropriate. The patient does have continued chronic pain complaints of the lumbar and cervical spine. Requested Terocin 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. 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." Also, California Medical Treatment Utilization Schedule recommendations the introduction of pain medications for the management of chronic pain to be introduced 1 at a time. Therefore, a formulation of medications with multiple agents would not be indicated. Also, California Medical Treatment Utilization Schedule stated that any compounded formulation that contains at least one drug or drug class that is not recommended, is not recommended. As such, the requested new Terocin 0.25% - 25%, #240 per 08/27/2013 RX is not medically necessary or appropriate.

Somnicin 2-50 100mg #30 per 08/27/13 RX: 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), Medical Foods.

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

Decision rationale: The requested Somnicin 2-50-100 mg, #30 per RX 08/27/2013 is not medically necessary or appropriate. The medication as proprietary combination of medical foods including melatonin, 5HTP, L-Tryptophan, pyridoxine, and magnesium. It is generally used to treat symptoms of anxiety, insomnia, and muscle relaxation. The clinical documentation submitted for review does not provide any indication of significant mood disturbances or insomnia that would benefit from medical food. Additionally, there is no documentation that the patient has failed to respond to non-pharmacological treatments. As such, the requested Somnicin 2-50-100 mg #30 is not medically necessary or appropriate.

Flurbiprofen #180 per 08/27/13/RX: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Other Medical Treatment

Guideline or Medical Evidence: 1.Skolnick P (1999) Antidepressants for the new millennium. Eur J Pharmacol 375:31-40.

Decision rationale: The requested flurbiprofen #180 as it is written on the prescription dated 08/27/2013 is not medically necessary or appropriate. The written prescription requests a compounded medication that includes flurbiprofen 20%/lidocaine 5%/amitriptyline 4%. California Medical Treatment Utilization Schedule does not recommend the use of nonsteroidal anti-inflammatory drugs as a topical agent unless there is documentation of failure to respond to oral analgesics. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to oral analgesics. Additionally, nonsteroidal anti-inflammatory drugs as topical agents are not supported for the use over the spinal area. Additionally, California Medical Treatment Utilization Schedule does not support the use of lidocaine in a cream as it is not an FDA-approved agent. Amitriptyline as a topical agent is also not supported by scientific evidence. Also, California Medical Treatment Utilization Schedule recommendations that medications for the management of chronic pain be introduced 1 at a time. Therefore, a compounded medication would not be supported by Guideline recommendations. As such, the requested flurbiprofen cream #180 as per 08/27/2013 RX is not medically necessary or appropriate.

Gabapentin 100% #180 per 08/27/13 RX: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111. 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 requested gabapentin 100% #180 per 08/27/2013 RX is not medically necessary or appropriate. The documentation indicates that the requested compound is gabapentin 10%/Cyclobenzaprine 6%/Tramadol 10%. California Medical Treatment Utilization Schedule does not recommend gabapentin or Cyclobenzaprine as topical agents due to lack of scientific evidence to support the efficacy of these elements. Additionally, peer reviewed literature does not support the use of Tramadol, again due to lack of scientific evidence to support efficacy. Also, California Medical Treatment Utilization Schedule recommends the use of medications for chronic pain be introduced 1 at a time. Therefore, a compounded medication would not be supported by Guideline recommendations. As such, the requested gabapentin 100% #180 per 08/27/2013 RX is not medically necessary or appropriate.