

<b>Case Number:</b>	CM13-0035343		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	05/18/2012
<b>Decision Date:</b>	04/14/2014	<b>UR Denial Date:</b>	09/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/17/2013

### 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 Family Medicine and is licensed to practice in Arizona. 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 42 year old female with a date of injury on 5/18/2012. She has been treated for ongoing symptoms in her lower back. Diagnoses include lumbar sprain/strain with radiculopathy and disc bulge, and depression. Subjective complaints include persistent low back pain. Physical exam shows muscle spasm in low back and decreased range of motion. Strength, sensation, and reflexes were noted as normal. MRI from 2012 showed 4mm disc protrusion at L5-S1. Nerve conduction studies showed lumbosacral plexopathy with a L5-S1 radiculopathy. Medication includes Norco, Flexeril, zolpidem, Anaprox, ultram, and Protonix. Submitted Final Determination Letter for IMR Case Number [REDACTED] documentation does not provide information on efficacy of medication or evidence of functional improvement.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE REQUEST FOR TEROGIN DOS: 5/26/13:** 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, Lidoderm Page(s): 111-113, 56.

**Decision rationale:** Terocin is a compounded medication that includes methyl Salicylate, menthol, lidocaine, and capsaicin. CA Chronic Pain Guidelines are clear that if the medication contains one drug that is not recommended the entire product should not be recommended. Topical lidocaine in the form of Lidoderm may be recommended for localized peripheral pain. No other commercially approved topical formulations of lidocaine are indicated. While capsaicin has some positive results in treating osteoarthritis, fibromyalgia and non-specific back pain, it has shown moderate to poor efficacy. Topical Salicylate has been demonstrated as superior to placebo for chronic pain to joints amenable to topical treatment. The menthol component of this medication has no specific guidelines or recommendations for its indication or effectiveness. In addition to capsaicin and menthol not being supported for use in this patient's pain, the medical records do not indicate the anatomical area for Terocin to be applied. Due to Terocin not being in compliance to current use guidelines the requested prescription is not medically necessary.

**RETROSPECTIVE REQUEST FOR GENICIN DOS: 5/26/13: 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 Page(s): 50.

**Decision rationale:** CA MTUS recommends glucosamine as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. For this patient the submitted documentation does not show evidence of ongoing osteoarthritis in the knee, and does not identify the intended use of this product. Therefore, the medical necessity of Genicin is not established.

**RETROSPECTIVE REQUEST FOR COMPOUNDED MEDICATION:  
AMITRIPTYLINE 2%/FLURBIPROFEN 10%/LIDOCAINE 5% DISPENSED  
DOS:5/26/13: 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 based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS, LIDODERM, 111-113, 56

**Decision rationale:** CA Chronic Pain Guidelines are clear that if the medication contains one drug that is not recommended the entire product should not be recommended. This product combines Flurbiprofen, Amitriptyline, and lidocaine. Guidelines do not recommend topical Amitriptyline as no peer-reviewed literature support their use. CA MTUS indicates that topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but with a diminishing effect over another 2-week period. CA MTUS also indicates that topical NSAIDs are not recommended for neuropathic pain as there is no

evidence to support their use. Lidocaine is only recommended as a dermal patch. No other commercially approved topical formulations of lidocaine are indicated. Furthermore, the medical record does not indicate the location for this medication to be used. For these reasons, the medical necessity of this medication is not established.

**RETROSPECTIVE REQUEST FOR COMPOUNDED MEDICATION:  
GABAPENTIN/CYCLOBENZAPRINE/TRAMADOL (DURATION AND FREQUENCY  
UNKNOWN) DISPENSED FOR LOW BACK/LEFT SCIATICA SYMPTOMS ON  
DOS:5/26/13: 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, AEDS, Page(s): 111-113, 16.

**Decision rationale:** CA Chronic Pain Guidelines are clear that if the medication contains one drug that is not recommended the entire product should not be recommended. This product combines gabapentin, cyclobenzaprine, and Tramadol. CA MTUS indicates that gabapentin is an anti-seizure medication that is recommended for neuropathic pain. CA MTUs also adds that following initiation of treatment there should be documentation of at least 30% pain relief and functional improvement. The continued use of an AED for neuropathic pain depends on these improved outcomes. The medical records do not indicate any pain relief or functional improvement specific to this medication. Guidelines also do not recommend topical gabapentin as no peer-reviewed literature support their use. Guidelines do not recommend topical cyclobenzaprine as no peer-reviewed literature support their use. Furthermore, muscle relaxers in general show no benefit beyond NSAIDS in pain reduction of which the patient was already taking. Furthermore, the patient is already taking oral Tramadol, and topical administration of Tramadol would not likely add further benefit. Therefore, the medical necessity of this compounded medication is not established.