

<b>Case Number:</b>	CM13-0061227		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	04/01/2011
<b>Decision Date:</b>	06/16/2014	<b>UR Denial Date:</b>	11/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/04/2013

### 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 Anesthesiology, has a subspecialty in Acupuncture 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 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 54 year old female who sustained an injury on 04/01/11 and was followed for multiple complaints including pain in the right shoulder wrist and pain in the foot. There were other diagnoses including radiculitis and carpal tunnel syndrome. As of 08/27/13 the patient was complaining of intermittent moderate low back pain and pain in the bilateral shoulders, left wrist, left foot, and bilateral foot/heel. The patient was receiving electro shockwave therapy in August of 2013. The clinical record from 09/20/13 noted continuing complaints of low back pain radiating to the lower extremities and moderate pain in the right shoulder and left wrist. On physical examination no specific findings were noted. No plan was documented. Toxicology results from 06/03/13 reported positive findings for Tramadol. There were no other positive findings. The following medication is being requested: Tramadol/L-Carnitine, Omeprazole 20MG, Glucosamine Sulfate 500MG, Terocin Topical Pain Relief 240MG, Flurbiprofen (NAP) Cream LA 180 grams, Gabacyclotram 180 grams.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TRAMADOL/L-CARNITINE 40/125MG #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS  
Page(s): 88-89.

**Decision rationale:** In regards to the request for tramadol with L- Carnitine 40/125mg quantity 90 this medication would not have been recommended as medically necessary based on clinical documentation submitted for review and current evidence based guidelines. The clinical documentation did not present with any clear indications that tramadol combined with L- Carnitine was providing any substantial functional improvement or pain reduction. Given the evidence of inconsistent use of tramadol without functional benefit or pain reduction the medical necessity of the requested item was not established. The requested item was not medically necessary.

**OMEPRAZOLE 20MG #60:** Upheld

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

**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, PROTON PUMP INHIBITORS

**Decision rationale:** In regards to omeprazole 20mg quantity 60 this reviewer would not have recommended this medication as medically necessary based on clinical documentation submitted for review and guideline recommendations. There was no indication from the clinical record that the patient had any significant side effects with the use of medications including gastrointestinal upset or acid reflux. There was no evidence in the clinical documentation supporting diagnosis of gastroesophageal reflux disease. Medical necessity of the requested item was not established. The requested item was not medically necessary.

**GLUCOSAMINE SULFATE 500MG #90:** Upheld

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

**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, GLUCOSAMINE

**Decision rationale:** In regards to the request for glucosamine 500mg quantity 90 this reviewer would not have recommended this medication as medically necessary. There was no evidence in the clinical documentation substantiating the presence of symptomatic osteoarthritis which would have benefitted from this medication. Given the absence of any clear symptomatic osteoarthritis in the clinical record medical necessity of the requested item was not established. The requested item was not medically necessary.

**TEROCIN TOPICAL PAIN RELIEF 240MG:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**Decision rationale:** In regards to terocin topical pain relief 240mg this reviewer would not have recommended this medication as medically necessary based on clinical documentation submitted for review and current evidence based guidelines. The CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. The clinical documentation provided did not discuss the claimant's prior medication use and did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound would not have been supported as medically necessary.

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**Decision rationale:** In regards to terocin topical pain relief 240mg this reviewer would not have recommended this medication as medically necessary based on clinical documentation submitted for review and current evidence based guidelines. The CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. The clinical documentation provided did not discuss the claimant's prior medication use and did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound would not have been supported as medically necessary.

**FLURBIPROFEN (NAP) CREAM LA 180 GRAMS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**Decision rationale:** In regards to the topical Flurbiprofen cream 180 grams, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The

CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Flurbiprofen which is not approved for transdermal use. The clinical documentation provided did not discuss the claimant's prior medication use and did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound would not have been supported as medically necessary.

**GABACYCLOTRAM 180 GRAMS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**Decision rationale:** In regards to the topical Gabapentin, cyclobenzaprine, and Tramadol 180 grams, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Gabapentin, cyclobenzaprine, and Tramadol which are not approved for transdermal use. The clinical documentation provided did not discuss the claimant's prior medication use and did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound would not have been supported as medically necessary.