

Case Number:	CM13-0071497		
Date Assigned:	01/08/2014	Date of Injury:	06/26/2011
Decision Date:	07/08/2014	UR Denial Date:	12/19/2013
Priority:	Standard	Application Received:	12/27/2013

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 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 injured worker is a 54 year old female, with a reported date of injury on 06/26/2011. The injury reportedly occurred when the worker was pushing a metal cart on a sloping floor. The injured worker complained of mid and lower back pain as well as bilateral shoulder pain and left elbow pain. The injured worker underwent an MRI of the lumbar spine, on 07/18/2011, images not available for review with the clinical documents provided. The results were reported as "abnormal" findings at the L3-L4 and L4-L5 levels. The injured worker had an MRI of the cervical spine dated July 17, 2012, reported as "abnormal" with degenerative changes and disc protrusions. The reports were also not available for review with the clinical documents provided. According to the progress note dated 01/04/2013, the injured worker presented with positive spurling's maneuvers. The injured worker had cervical spine flexion of 45 degree, extension of 46 degrees, left rotation at 72 degrees and right lateral flexion at 35 degrees. Range of motion in right and left Shoulders documented as normal bilaterally. The injured workers medication regimen was not provided with the clinical documents available for review. The request for authorization of the medical request was submitted on 12/26/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

3 PRESCRIPTIONS OF TEROGIN Lotion 240G (DOS 11/15/12, 3/28/13 AND 6/24/13 BETWEEN 11/15/12 AND 6/24/13): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LIDOCAINE, CAPSAICIN, TOPICAL ANALGESICS Page(s): 56, 105, 112.

Decision rationale: The request for 3 prescriptions of Terocin lotion 240G (DOS 11/15/12, 3/28/13 and 6/24/13 between 11/15/12 AND 6/24/13) is non-certified. According to the CA MTUS guidelines any compounded product that contains at least one drug that is not recommended is not recommended. Terocin contains lidocaine. The guidelines state that topical lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first line therapy such as gabapentin or lyrica. Topical lidocaine in the form of the dermal patch, Lidoderm, has been FDA approved for neuropathic pain. No other commercially approved topical formulation of lidocaine are indicated for neuropathic pain. The capsaicin component of the Terocin, according to the CA MTUS guidelines is recommended only as an option in patients who have not responded to or are intolerant to other treatments. In addition topical salicylates are not indicated for the treatment of neuropathic pain or osteoarthritis of the spine, hip or shoulder. The injured workers complaints were to the cervical and lumbar spine. It did not appear the injured worker had a diagnosis which would indicate their need for topical capsaicin. It did not appear the injured worker was intolerant of or had not responded to other treatments. Additionally, the guidelines note other topical formulations of Lidocaine, other than lidoderm, are not recommended. The request for 3 prescriptions of Terocin lotion 240G (DOS 11/15/12, 3/28/13 and 6/24/13 between 11/15/12 and 6/24/13) is not medically necessary.

1 PRESCRIPTION OF TEROGIN PATCH #30, (BETWEEN 10/4/13 AND 10/4/13):

Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LIDOCAINE, CAPSAICIN, TOPICAL ANALGESICS Page(s): 56, 105, 112.

Decision rationale: The request for 1 prescription of Terocin patch #30, (between 10/4/13 AND 10/4/13) is non-certified. According to the CA MTUS guidelines any compounded product that contains at least one drug that is not recommended is not recommended. Terocin contains lidocaine. The guidelines state that topical lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first line therapy such as gabapentin or lyrica. Topical lidocaine in the form of the dermal patch, Lidoderm, has been FDA approved for neuropathic pain. No other commercially approved topical formulation of lidocaine are indicated for neuropathic pain. The capsaicin component of the Terocin, according to the CA MTUS guidelines is recommended only as an option in patients who have not responded to or are intolerant to other treatments. In addition topical salicylates are not indicated for the treatment of neuropathic pain or osteoarthritis of the spine, hip or shoulder. The injured workers pain complaints of pain are of the spine and shoulder. It did not appear the injured worker had a diagnosis which would indicate their need for topical capsaicin. It did not appear the injured

worker was intolerant of or had not responded to other treatments. Additionally, the guidelines note other topical formulations of Lidocaine, other than Lidoderm, are not recommended. Therefore, the request for 1 prescription of Terocin patch #30, (between 10/4/13 and 10/4/13) is not medically necessary.

3 PRESCRIPTIONS OF KETOPROFEN (NAP) CREAM-L, 180G (DOS 11/15/12, 3/28/13 AND 6/24/13 BETWEEN 11/15/12 AND 6/24/13): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, TOPICAL ANALGESICS Page(s): 56, 105, 111-113.

Decision rationale: The request for 3 prescriptions of Ketoprofen (NAP) Cream-L, 180G (DOS 11/15/12, 3/28/13 and 6/24/13 between 11/15/12 and 6/24/13) is non-certified. According to the CA MTUS guidelines, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Ketoprofen is not currently FDA approved for a topical application. Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms. Furthermore, there is a lack of documentation in regards to the injured worker failing trial treatments of antidepressants and anticonvulsants. Therefore, the request for 3 prescriptions of Ketoprofen (NAP) Cream-L, 180G (DOS 11/15/12, 3/28/13 and 6/24/13 between 11/15/12 and 6/24/13) is not medically necessary.

1 PRESCRIPTION OF FLURBI (NAP) CREAM-LA 180G (BETWEEN 10/4/13 AND 10/4/13): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, FLURBIPROFEN Page(s): 72, 105, 111-113.

Decision rationale: The request for 1 prescription of Flurbi (NAP) Cream-LA 180G (between 10/4/13 and 10/4/13) is non-certified. According to the CA MTUS guidelines Flurbiprofen's maximum daily dose is 300mg/day and the maximum divided dose is 100 mg twice a day. According to the CA MTUS guidelines, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms. Furthermore, there is a lack of documentation in regards to the injured worker failing trial treatments of antidepressants and anticonvulsants. As the request is unclear as to what amount and where the injured worker is to utilize this cream the request for 1 prescription of Flurbi (NAP) Cream-LA 180G (between 10/4/13 and 10/4/13) is not medically necessary.

3 PRESCRIPTIONS OF SOMICIN #90 (DOS 11/15/12, 3/28/13 AND 6/24/13 BETWEEN 11/15/12 AND 6/24/13): 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) and National Guidelines Clearinghouse.

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

Decision rationale: The request for 3 prescriptions of Somicin #90 (DOS 11/15/12, 3/28/13 and 6/24/13 between 11/15/12 and 6/24/13) is non-certified. According to previous utilization review the request was made for Somnicin to be utilized due to insomnia. According to the Official Disability Guidelines insomnia medications should only be used after careful evaluation of potential causes for sleep disturbance. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and or psychological measures. The specific component of insomnia should be addressed. As there is a lack of clinical documentation provided that addresses the injured workers sleep disturbances or previous treatments. The efficacy of the medication was unclear within the provided documentation. As such, the request for 3 prescriptions of Somicin #90 (DOS 11/15/12, 3/28/13 and 6/24/13 between 11/15/12 and 6/24/13) are not medically necessary.

3 PRESCRIPTIONS OF GENICIN 500MG, #90 (DOS 11/15/12, 3/28/13 AND 6/24/13 BETWEEN 11/15/12 AND 6/24/13): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GLUCOSAMINE (AND CHONDROITIN SULFATE).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GLUCOSAMINE Page(s): 50.

Decision rationale: The request for 3 prescriptions of Genicin 500MG, #90 (DOS 11/15/12, 3/28/13 and 6/24/13 between 11/15/12 and 6/24/13) is non-certified. According to the CA MTUS guidelines Genicin (Glucosamine) is recommended in patients with moderate arthritis pain, especially knee osteoarthritis. The official Disability Guidelines state that glucosamine is not recommended for low back pain. The injured workers main complaints involve the lower back and shoulder. As glucosamine is not recommended for low back pain the request for 3 prescriptions of Genicin 500MG, #90 (DOS 11/15/12, 3/28/13 and 6/24/13 between 11/15/12 and 6/24/13) is not medically necessary.

3 PRESCRIPTIONS OF KETO/GABA/CYCLO 20/6/4%, 180G (DOS 11/15/12, 3/28/13 AND 6/24/13 BETWEEN 11/15/12 AND 6/24/13): 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, NSAIDS, GABAPENTIN, CYLCYBENZAPIRNE Page(s): 41, 56, 105 , 111-113.

Decision rationale: The request for 3 prescriptions of Keto/Gaba/Cyclo 20/6/4%, 180G (DOS 11/15/12, 3/28/13 and 6/24/13 between 11/15/12 and 6/24/13) is non-certified. According to the CA MTUS guidelines, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Ketoprofen is not currently FDA approved for a topical application; topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms. According to the CA MTUS guideline Gabapentin is also not recommended. The addition of Cyclobenzaprine is not recommended by CA MTUS guidelines. Furthermore, according to the CA MTUS guidelines if any compounded product that contains at least one drug that is not recommended is not recommended for use. In addition, there is no documentation of failed trials of antidepressant and anticonvulsants. Therefore, the request for 3 prescriptions of Keto/Gaba/Cyclo 20/6/4%, 180G (DOS 11/15/12, 3/28/13 and 6/24/13 between 11/15/12 and 6/24/13) is not medically necessary.

1 PRESCRIPTION OF GABA/CYCLO/TRAMA 10/6/10% (BETWEEN 10/4/13 AND 10/4/13): 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, NSAIDS, GABAPENTIN, CYLCYBENZAPIRNE Page(s): 41, 56, 105,111-113.

Decision rationale: The request for 1 prescription of Gaba/Cyclo/Trama 10/6/10% (between 10/4/13 and 10/4/13) is non-certified. According to the CA MTUS guideline Gabapentin is not recommended. The addition of Cyclobenzaprine is not recommended by CA MTUS guidelines. According to the CA MTUS guidelines, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms. Furthermore, there is a lack of documentation is regards to the injured worker failing trial treatments of antidepressants and anticonvulsants. Many agents are compounded as monotherapy or combination for pain control including opioids, there is little to no research to support the use of many of these agents. Furthermore, according to the CA MTUS guidelines if any compounded product that contains at least one drug that is not recommended is not recommended for use. Therefore, the request for 1 prescription of Gaba/Cyclo/Trama 10/6/10% (between 10/4/13 and 10/4/13) is not medically necessary.

1 PRESCRIPTION OF LAXACIN 100GM (BETWEEN 11/15/12 AND 10/4/13): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation McKay SL, et al. Management of Constipation.

Iowa City (IA); University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core; 2009 Oct. 51p.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 77.

Decision rationale: The request for 1 prescription of Laxacin 100GM (between 11/15/12 and 10/4/13) is non-certified. According to the CA MTUS guidelines note prophylactic treatment for constipation should be initiated with opioid use. The clinical documentation provided lacks information regarding opioid use by the injured worker. The efficacy of the medication was unclear. The requesting physician did not indicate the rationale for the medication. Therefore, the request for 1 prescription of Laxacin 100GM (between 11/15/12 and 10/4/13) is not medically necessary.