

<b>Case Number:</b>	CM14-0139296		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	03/25/2014
<b>Decision Date:</b>	10/03/2014	<b>UR Denial Date:</b>	07/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2014

### 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 Occupational Medicine 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 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:

According to the records made available for review, this is a 53-year-old female with a 3/25/14 date of injury. At the time (7/31/14) of the Decision for Gabapentin/Pyridoxine 250mg/10mg #60, Flurbiprofen/Cyclo/Menth cream 20%/10%/4% 180 gm, Keratek analgesic gel 4 oz, Hydrocodone/APAP/ondan 10/300/2mg #40, and Orphenadrine/Caffeine 50/10mg #60, there is documentation of subjective (marked right shoulder pain with marked weakness to overhead activities, right elbow pain with severe tenderness of lateral aspect, right wrist pain with clicking and aching, right knee pain with locking and catching, right hip pain with clicking, tightness, and spasm, and low back pain with radiation to the right leg) and objective (pain to palpation over anterior aspect of shoulder, grip strength decreased on right, supraspinatus motor strength 4+/5, impingement tests I and II positive, drop arm test positive, tenderness about lateral epicondyle right elbow, tenderness about dorsal aspect with clicking and catching at the radio ulnar joint consistent with triangular fibrocartilage tear, antalgic gait, pain to palpation over medial joint line, and positive McMurray's and Steinman's test) findings, current diagnoses (clinical evidence of a possible rotator cuff tear of the right shoulder, lateral epicondylitis of the right elbow, triangular fibrocartilage of right wrist, abductor strain and tendinitis of right hip, right knee medial meniscus tear, and disc herniation at L5-S1 articulation of the lumbar spine), and treatment to date (physical therapy, bracing, and activity modifications). It cannot be determined whether the patient has been taking Gabapentin/Pyridoxine, Flurbiprofen/Cyclo/Menth cream, Keratek analgesic gel, Hydrocodone/APAP/ondan 10/300/2mg #40, and Orphenadrine/Caffeine. Regarding Gabapentin/Pyridoxine 250mg/10mg #60, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Gabapentin/Pyridoxine use to date. Regarding Keratek analgesic gel 4 oz, there is no documentation that trials of antidepressants and

anticonvulsants have failed and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Keratek use to date. Regarding Hydrocodone/APAP/ondan 10/300/2mg #40, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, functional benefit or improvement as a reduction in work restrictions; and an increase in activity tolerance; and/or a reduction in the use of medications as a result of Hydrocodone/APAP/ondan use to date, and nausea and vomiting secondary to chemotherapy and radiation treatment, postoperative use, or acute use for gastroenteritis. Regarding Orphenadrine/Caffeine 50/10mg #60, there is no documentation of acute exacerbation of chronic low back pain, the intention to treat over a short course, and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Orphenadrine/Caffeine use to date.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Gabapentin/Pyridoxine 250mg/10mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin), Page(s): 18-19. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (gabapentin). MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnosis of clinical evidence of a possible rotator cuff tear of the right shoulder, lateral epicondylitis of the right elbow, triangular fibrocartilage of right wrist, abductor strain and tendinitis of right hip, right knee medial meniscus tear, and disc herniation at L5-S1 articulation of the lumbar spine. In addition, there is documentation of neuropathic pain. However, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Gabapentin/Pyridoxine use to date. Therefore, based on guidelines and a review of the evidence, the request for Gabapentin/Pyridoxine 250mg/10mg #60 is not medically necessary.

**Flurbiprofen/Cyclo/Menth cream 20%/10%/4% 180 gm: Upheld**

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

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

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that Ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnosis of clinical evidence of a possible rotator cuff tear of the right shoulder, lateral epicondylitis of the right elbow, triangular fibrocartilage of right wrist, abductor strain and tendinitis of right hip, right knee medial meniscus tear, and disc herniation at L5-S1 articulation of the lumbar spine. However, the requested Flurbiprofen/Cyclo/Menth cream 20%/10%/4% 180 gm contains at least one drug (Cyclobenzaprine) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Flurbiprofen/Cyclo/Menth cream 20%/10%/4% 180 gm is not medically necessary.

**Keratek analgesic gel 4 oz:** 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 based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:

(<http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=5527b965-615b-4eff-8597-8c3e2e626f61>); Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** An online search identifies Keratek gel as a topical compounded analgesic medication consisting of Menthol 16% and Methyl Salicylate 28%. MTUS Chronic Pain Medical Treatment Guidelines identifies that topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnosis of clinical evidence of a possible rotator cuff tear of the right shoulder, lateral epicondylitis of the right elbow, triangular fibrocartilage of right wrist, abductor strain and tendinitis of right hip, right knee medial meniscus tear, and disc herniation at L5-S1 articulation of the lumbar spine. In addition, there is documentation of neuropathic pain. However, there is no documentation that trials of antidepressants and anticonvulsants have failed. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Keratek analgesic gel use to date. Therefore,

based on guidelines and a review of the evidence, the request for Kera-Tek Gel 4oz is not medically necessary.

**Hydrocodone/APAP/ondan 10/300/2mg #40: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Page(s): 74-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Antiemetics (for opioid nausea) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of nausea and vomiting secondary to chemotherapy and radiation treatment, postoperative use, or acute use for gastroenteritis, as criteria necessary to support the medical necessity of Ondansetron (Zofran). Within the medical information available for review, there is documentation of diagnosis of clinical evidence of a possible rotator cuff tear of the right shoulder, lateral epicondylitis of the right elbow, triangular fibrocartilage of right wrist, abductor strain and tendinitis of right hip, right knee medial meniscus tear, and disc herniation at L5-S1 articulation of the lumbar spine. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Hydrocodone/APAP/ondan use to date. Furthermore, there is no documentation of nausea and vomiting secondary to chemotherapy and radiation treatment, postoperative use, or acute use for gastroenteritis. Therefore, based on guidelines and a review of the evidence, the request for Hydrocodone/APAP/ondan 10/300/2mg #40 is not medically necessary.

**Orphenadrine/Caffeine 50/10mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle relaxant. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended for short-term (less than two weeks) treatment. Within the medical information available for review, there is documentation of diagnosis of clinical evidence of a possible rotator cuff tear of the right shoulder, lateral epicondylitis of the right elbow, triangular fibrocartilage of right wrist, abductor strain and tendinitis of right hip, right knee medial meniscus tear, and disc herniation at L5-S1 articulation of the lumbar spine. However, there is no documentation of acute exacerbation of chronic low back pain and the intention to treat over a short course (less than two weeks). In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Orphenadrine/Caffeine use to date. Therefore, based on guidelines and a review of the evidence, the request for Orphenadrine/Caffeine 50/10mg #60 is not medically necessary.