

<b>Case Number:</b>	CM14-0053252		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	09/03/2009
<b>Decision Date:</b>	08/18/2014	<b>UR Denial Date:</b>	03/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 64-year-old male who reported an injury on 09/03/2008. The mechanism of injury was not stated. The current diagnoses include right shoulder full rotator cuff tear, status post left shoulder surgery, bilateral elbow cubital tunnel syndrome, bilateral carpal tunnel syndrome and status post left wrist/hand surgery. The injured worker was evaluated on 02/26/2014 with complaints of persistent left shoulder pain, right elbow pain, right wrist/hand pain, and occasional left wrist/hand/thumb pain. Physical examination on that date revealed 170 degree forward flexion of the bilateral shoulders, 35 degree extension, 170 degree abduction, 50 degree adduction, 70 degree internal rotation, 80 degree external rotation, tenderness at the subacromial space, and 60 degree flexion and extension of the bilateral wrists with 20 to 25 degree radial and ulnar deviation. Treatment recommendations at that time included prescriptions for Naproxen Sodium 550mg, Omeprazole 20mg, 3 compounded creams, Genicin, and Somnicin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Xolido 2% cream (Lidocaine): 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 rationale:** California MTUS Guidelines state Lidocaine is indicated for neuropathic or localized peripheral pain after there has been evidence of a trial of first line therapy. No commercially approved topical formulation of Lidocaine (cream, lotion, or gel) is indicated for neuropathic pain. Therefore, the current request cannot be determined medically appropriate. There was also no frequency or quantity listed in the current request. As such, the request is not medically necessary.

**Terocin pain patches (Capsaicin, Methyl salicylate, Menthol) #20:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

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

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. There is also no strength or frequency listed in the current request. As such, the request is not medically necessary.

**Flurbi cream LA (Flubiprofen, Lidocaine, Amitriptyline) 180 grams:** 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 rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. The only FDA approved topical NSAID is Diclofenac. Lidocaine is not indicated in the form of a cream. There is also no strength or frequency listed in the current request. As such, the request is not medically necessary.

**Gabacyclotram (Gabapentin, Cyclobenzaprine, Tramadol) 180 grams:** 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 rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. Gabapentin is not recommended as there is no evidence for the use of an anticonvulsant as a topical product. Cyclobenzaprine is also not recommended as a topical product. There is also no strength or frequency listed in the current request. As such, the request is not medically necessary.

**Somnicin (Melatonin, 5HTP, L-Tryptophan, Pyridoxine, Magnesium) #30:** 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) Pain Chapter.

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

**Decision rationale:** Official Disability Guidelines state insomnia treatment is recommended based on etiology. Nonpharmacologic treatment includes waking at the same time every day, maintaining a consistent bedtime, exercising, keeping the bedroom quiet and cool, avoiding caffeine and nicotine prior to bedtime, drinking in moderation, and avoiding napping. The injured worker does not maintain a diagnosis of insomnia or sleep disorder. There is also no documentation of a failure to respond to nonpharmacologic treatment prior to the initiation of a prescription product. As the medical necessity has not been established, the request cannot be determined as medically appropriate. There was also no frequency listed in the current request. As such the request is not medically necessary.