

<b>Case Number:</b>	CM14-0088176		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	08/04/2011
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	06/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2014

### 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:

The patient is a 59 year-old male with date of injury 08/04/2011. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 05/23/2014, lists subjective complaints as right shoulder pain and low back pain. PR-2 provided for review was handwritten and illegible. Objective findings: Examination of the right shoulder revealed tenderness to palpation over the posterior cervical spine with Subscapularis spasms. Range of motion was decreased and motions were accomplished with the patient expressing complaints of pain during the maneuvers. Sensation was intact to light touch and pinprick of all dermatomes in the bilateral upper extremities. Examination of the lumbar spine revealed tenderness to palpation of the paravertebral muscles with spasm and restricted range of motion in all planes due to pain. Diagnosis: Right shoulder strain/sprain, Rotator cuff tear, Displacement of lumbar intervertebral disc without myelopathy. The medical records provided for review document that the patient had not been prescribed the following medications before the request for authorization on 05/23/2014. No SIG was found for the following medications. Medications: Xolido 2%, Terocin 240gm, Flurbi (NAP) cream, 180gm Somnicin, and #30 Gabacyclobin 180gm.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Xolido 2%:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

**Decision rationale:** The MTUS recommends lidocaine patches only for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Lidocaine is currently not recommended for a non-neuropathic pain. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. Therefore, Xolido 2% is not medically necessary.

**Functional Capacity Exam:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Fitness for Duty Chapter.

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

**Decision rationale:** The Official Disability Guidelines state that a functional capacity evaluation is appropriate if, case management is hampered by complex issues and the timing is appropriate; such as if the patient is close to being at maximum medical improvement or additional clarification concerning the patient's functional capacity is needed. Functional capacity evaluations are not needed if the sole purpose is to determine a worker's effort or compliance, or the worker has returned to work. There is no documentation in the medical record to support a functional capacity evaluation based on the above criteria. Therefore, Functional Capacity Exam is not medically necessary.

**Terocin 240 gm:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

**Decision rationale:** The active ingredients of Terocin are: menthol 4% and lidocaine 4%, and is classified as a topical analgesic. The MTUS does not recommend topical analgesics unless trials of antidepressants and anticonvulsants have failed. The medical record does not document failed attempts to alleviate the patient's pain with either antidepressants or anticonvulsants. Terocin 240mg is not medically necessary.

**Flurbi (NAP) Cream 180 gm:** Upheld

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

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

**Decision rationale:** According to the MTUS, there is little to no research to support the use of many of these Compounded Topical Analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen topical is not supported by the MTUS. Therefore, Flurbi (NAP) Cream 180 gm is not medically necessary.

**Somnicin #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, pain (chronic).

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

**Decision rationale:** The Official Disability Guidelines recommend a melatonin as a single agent to improve sleep. The repeated administration of melatonin improves sleep and thereby may reduce anxiety, which leads to lower levels of pain. Somnicin is a compounded medication. Melatonin compounded with other substances is not recommended. Therefore, Somnicin #30 is not medically necessary.

**Gabacyclobin 180 gm:** 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 Page(s): 111-113.

**Decision rationale:** According to the MTUS, there is little to no research to support the use of many of these Compounded Topical Analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended. There is no peer-reviewed literature to support use. There is no evidence for use of any muscle relaxant as a topical product. Therefore, Gabacyclobin 180 gm is not medically necessary.