

<b>Case Number:</b>	CM14-0193453		
<b>Date Assigned:</b>	11/26/2014	<b>Date of Injury:</b>	02/03/2007
<b>Decision Date:</b>	01/13/2015	<b>UR Denial Date:</b>	11/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2014

### 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 Physical Medicine & Rehabilitation and Pain Management, has a subspecialty in Interventional Spine 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 47 year old male with the injury date of 02/03/07. Per treating physician's report 09/23/14, the patient presents pain in his lower back, radiating down his left leg. The patient rates his back pain as 7/10. His lumbar flexion is 35 degrees, extension is 10 degrees and lateral flexion is 15 degrees bilaterally. Diagnosis is s/p lumbar spine surgeries X2. The patient was provided Menthoderm gel 120gm 'for the treatment of temporary relief of minor aches and pain and Calypso cream, Theramine' Thepadone and Ambien. The treater requests Terocin cream. The treater mentions that the efficacy of medication will be reviewed upon the patient's return visit. Per progress report 06/19/14, the patient has same lower back pain, rating 8/10. The utilization review determination being challenged is dated on 11/07/14. Treatment reports were provided from 02/12/14 to 09/23/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**(1) Terocin 120ml:** 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 topical lidocaine Page(s): 112.

**Decision rationale:** The patient presents with pain and weakness in his lower back and left leg. The patient is s/p 2 lumbar surgeries and the names or dates of surgeries are not provided. The request is for TEROGIN #120ml. Terocin cream is considered a topical analgesic and contains methyl salicylate, capsaicin, lidocaine and menthol. MTUS guidelines page 112 on topical lidocaine states, "Recommended 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). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain." MTUS also states, "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." For salicylate, a topical NSAID, MTUS does allow it for peripheral joint arthritis/tendinitis problems. However, the patient does not present with peripheral joint problems to warrant a compound product with salicylate. Furthermore, the MTUS guidelines do not allow any other formulation of Lidocaine other than in patch form. In this case, guidelines do not recommend a compounded product if one of the compounds are not indicated for use. Neither lidocaine, nor salicylate is indicated for this patient. Furthermore, the treater does not indicate the % of compound products. Request is not medically necessary.

**(1) Flurbi (NAP) Cream-LA 180mg: 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 topical analgesic Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, topical analgesic

**Decision rationale:** The patient presents with pain and weakness in his lower back and left leg. The patient is s/p 2 lumbar surgeries and the names or dates of surgeries are not provided. The request is for FLURBIPROFEN (NAP) cream- LA 180mg. MTUS guideline page 111 recommends Non-steroidal anti-inflammatory agents (NSAIDs) as topical analgesics for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment for short-term use (4-12 weeks)." ODG guidelines have the following regarding topical analgesics: (<http://www.odg-wc.com/odgtwc/pain.htm#TreatmentProtocols>) "There is little to no research to support the use of many these agents. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. "In this case, none of the reports indicate that patient's Osteoarthritis and tendinitis, in particular, that of the knee or other joints. Request is not medically necessary.

**Norco 10/325mg #60: 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 Medications for chronic pain; criteria for use of opioids Page(s): 60,61;76-78;88-89.

**Decision rationale:** The patient presents with pain and weakness in his lower back and left leg. The patient is s/p 2 lumbar surgeries and the names or dates of surgeries are not provided. "The patient has been utilizing Norco since at least 04/01/14. Urine drug screens were conducted on 03/12/14 and on 07/16/14. Regarding chronic opiate use, MTUS guidelines page and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The review of the reports does not show any discussion specific to this medication. The four A's including analgesia, ADL's, side effects, and aberrant drug seeking behavior are not addressed. There are no before and after pain scales, and no urine drug screens as required by the MTUS. Given the lack of sufficient documentation demonstrating efficacy for chronic opiate use, the patient should slowly be weaned as outlined in MTUS guidelines. The utilization review letter 11/07/14 certified #30, stating "the guidelines recommends weaning of certain medications. The additional #30 is not indicated until there is adequate documentation of this medication's efficacy. The request for Norco #60 at this time is not medically necessary.

**Ambien 10mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental/stress chapter, Insomnia treatment

**Decision rationale:** The patient presents with pain and weakness in his lower back and left leg. The patient is s/p 2 lumbar surgeries and the names or dates of surgeries are not provided. Per utilization review letter 11/07/14 certified #15, stating "the guidelines recommend weaning of certain medications. ODG guidelines have the following regarding Ambien for insomnia: "Zolpidem [Ambien (generic available), Ambien CR]] is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien CR to be effective for up to 24 weeks in adults."In this case, the patient has been utilizing this medication prior to 03/12/14. The treater does not explain that this is to be used for short-term. There is no discussion as to how it is working. Given that the ODG guidelines only support a short-term use of this medication (7 days or so), and lack of documentation for a short-term use. The utilization review letter 11/07/14 already certified #15, stating "the guidelines recommends weaning of certain medications. The request for Ambien #30 at this time is not medically necessary.